MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS

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HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS

TUESDAY, MAY 22, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 3:04 p.m., in room 1102, Longworth House Office Building, Hon. Fortney Pete Stark (Chairman of the Subcommittee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
May 15, 2007
HL–12

CONTACT: (202) 225–3943

Chairman Stark Announces a Hearing on Medicare Advantage Private Fee-For-Service Plans

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on Medicare Advantage Private Fee-For-Service plans. **The hearing will take place at 2:00 p.m. on Tuesday, May 22, 2007, in Room 1100, Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Private Fee-For-Service (PFFS) plans have been available in Medicare since the Balanced Budget Act of 1997 (P.L. 105–33), but have experienced enormous growth following Medicare Advantage (MA) payment increases made by the Medicare Modernization Act of 2003 (P.L. 108–173). In 2003, less than 26,000 beneficiaries were enrolled in PFFS plans, but by April 2007 that number had exploded to nearly 1.5 million—a growth of more than 5600 percent. Exponential growth in PFFS raises numerous policy concerns.

According to the Medicare Payment Advisory Commission (MedPAC), MA Plans are paid on average 112 percent of fee-for-service Medicare. However, PFFS plans are located in geographic areas where payments are on average 119 percent of what it would cost to care for the same beneficiaries in traditional Medicare. Continued enrollment growth in these overpaid plans results in increased premiums for all Medicare beneficiaries and shortened solvency of the Hospital Insurance Trust Fund.

Private Fee-For-Service plans are very different from other MA plans. They are exempt from many of the rules and reporting requirements that apply to other MA plans. For example, PFFS plans are not required to: collect and report Health Plan Employer Data and Information Set (HEDIS®) quality data; coordinate care; conduct utilization review; or, have standards for timeliness of access to care. These plans generally do not have a network of providers, and advertise the ability of enrollees to choose any provider.

The law requires PFFS to pay non-contract providers at least the original Medicare rate. Providers, however, are not required to accept PFFS plan enrollees, and physicians can balance bill patients beyond the plan payment. Some providers around the country have refused to treat patients in PFFS plans. Like other MA plans, PFFS plans have widely varying co-payment structures that may lead to increased or decreased out of pocket costs for beneficiaries depending on what type of care is required.

Advocates for senior citizens and insurance commissioners across the country have reported numerous abuses by insurance agents and brokers selling PFFS plans. According to reports, some beneficiaries have been enrolled in PFFS plans with little or no knowledge of what they were signing up for. Beneficiaries have also

reported surprise when learning their preferred provider will not accept their PFFS plan.

In announcing this hearing, Chairman Stark said: **"The alarming growth in Private Fee-For-Service plans raises serious questions about their effect on the Medicare program. These plans are paid an average of 119 percent of traditional fee for service, even though beneficiaries are being told PFFS plans are no different than traditional fee-for-service Medicare. It is our duty to investigate the exponential growth and continued overpayments to PFFS plans, and to ensure beneficiaries are protected and taxpayer dollars are spent wisely."**

FOCUS OF THE HEARING:

The hearing will focus on Medicare Advantage Private Fee-For-Service plans.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*110th Congress*" from the menu entitled, "*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record.*" Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Tuesday, June 5, 2007**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, and telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. The hearing will begin. Today we are going to talk about the Medicare Advantage (MA) program. We will have a chance to review the Administration's message machine. I suspect most of you heard last night what I imagine they will repeat today, but I do hope that today's hearing will contribute to some rational review of the MA program.

To that end, I am going to reverse the panels and hope that we will have a chance then to have a response from the Centers for Medicare and Medicaid Services (CMS) to the witnesses who will appear representing a variety of views and concerns, including a good deal of support for the MA offerings, which are the focus of today's hearing.

According to the Medicare Payment Advisory Commission (MedPAC), the plans are paid, on average, about 119 percent of fee-for-service rates—I am referring here to the Private Fee-for-Service plans—and rising up to, in some cases, 150 percent of more in some areas. Since business follows the money, it is not surprising that enrollment is growing rapidly, some 5600 percent between the period 2002 and 2007.

Even so, there are only about 1,300,000 people, about 3 percent of all beneficiaries, in the Private Fee-for-Service plans now. Given that half of the projected MA growth is in this option, I think it is important that we evaluate its value before it becomes unmanageable.

Unlike most of the MA options, these plans don't typically have a network of providers. They are marketed as operating the same as traditional Medicare, but with supposedly lower cost-sharing and perhaps other additional benefits. Yet the reality often fails to match the sales pitches.

The plans may offer flat copayments for physician visits, but physician copayments of even $15 to $20 can often be higher than the 20 percent copayments in traditional Medicare. In addition, some of these plans tend to charge higher cost-sharing for certain Medicare coverage services, like skilled nursing facilities, home health, and durable medical equipment. My guess is that this is not coincidental. If you don't want sick people in your plan, you charge more for services that sick people need.

While these plans promote the able to see any provider, they neglect to mention that providers are not required to accept the plan's payment terms and that providers can decide on a per-visit basis whether to participate, even if it is the same patient returning for a second visit. They can decide at that point to drop the patient. Beneficiaries who have signed up for these plans are just beginning to confront these confusing problems.

I would like to ask unanimous consent to submit for the record a letter from the California Medical Association. They have become so disgruntled with Private Fee-for-Service plans that they are asking us to eliminate this option altogether. I will, as I say, put the letter, without objection, in the record.

We will also hear today about the difficulty faced by insurance commissioners in attempting to regulate sales practices of these products. High profit margins have provided incentives for plan sponsors to offer large commissions to sell these plans, and I am afraid if you think that used car salesmen are bad, they have noth-

ing on some of the hucksters who are promoting these plans today. We will hear about outright fraud and intentional and unintentional misrepresentation.

Yet the original Medicare Modernization Act of 2003 prohibited State oversight of these products. The Administration has dragged its feet on requiring better behavior and enforcing the rules that are in effect. Even worse, they have interfered at times with the limited ability retained by the States with respect to oversight on agents and brokers.

I understand that in last night's press releases, the Administration has suggested they are making some changes. We will hear more about those later.

Private Fee-for-Service plans are exempt from MA quality and plan adequacy requirements, so we are unable to determine what if any value these plans provide. I look forward to discussing this loophole day.

We will also hear from one actual plan today whose situation is unique. It is Mr. Camp's local plan, and it deserves credit for their willingness to appear today. I gather we were left with no other choices, as most prominent plans declined the offer to enlighten us. It is a special plan, and it is a product that has an interesting future. I look forward to hearing from this Michigan plan and its prospects.

The Subcommittee has a responsibility to provide oversight and ensure that the beneficiaries and the taxpayers are both getting value and quality for their investment. The Private Fee-for-Service plans appear to provide far better value to their shareholders and their companies' bottom lines than they do to Medicare and its beneficiaries.

As I have said all year, we look to improve and protect Medicare. All provider payments must be reviewed and are subject to change. Given what we know about Private Fee-for-Service at this time, they are high on the list. I look forward to today's testimony, and I would like to yield to Mr. Camp for any opening statement he would like to make.

Mr. CAMP. Thank you, Chairman Stark. In recent months, we have heard a steady stream of calls to cut Medicare payments to MA plans. In response, the National Association for the Advancement of Colored People, League of United Latin American Citizens, and the Jewish Guild for the Blind have all come forward alerting us that these Medicare cuts would significantly and disproportionately harm the minority and low-income beneficiaries that these groups represent.

Today we will hear about one type of MA plan, known as Private Fee-for-Service. Private Fee-for-Service plans are one of the most popular MA choices available for Medicare beneficiaries. In fact, 59 percent of all rural MA enrollees have chosen a Private Fee-for-Service plan.

We must recognize the value that Private Fee-for-Service plans provide to Medicare beneficiaries. Today we will hear from a witness from my home State of Michigan who will talk about the 116,000 retired teachers, janitors, bus drivers, and school cafeteria workers who are currently enrolled in a Private Fee-for-Service plan. These union retirees depend on the flexibility their Private

Fee-for-Service plan provides, because of its ability to provide extra benefits, regardless of where they have chosen to retire.

I'd also like to ask for unanimous consent to submit a letter from the Michigan Association of Retired School Personnel. In this letter, their Executive Director states that their members "depend on adequate funding" of Medicare advantage, and that any cuts will result in "reduced coverage for much needed medical services for the retirees or reduced funding for classroom efforts at educating our children."

Their members are also enjoying the "increased simplicity" that their MA Private Fee-for-Service plan has brought. This letter states that "retired school employees previously had to deal with the confusion of coordinating Medicare with a supplemental plan." Now they receive their entire Medicare benefit under one consolidated plan.

Mr. Chairman, I hope that prior to any effort to cut these plans, we will consider the well-being of seniors living in rural districts like mine and the thousands of retired public school employees that I represent. Congress should seek to improve MA for both beneficiaries and taxpayers alike. Let's work together to strengthen Medicare's marketing and enrollment guidelines and improve MA for America's seniors and people with disabilities.

I yield back the balance of my time.

[The information follows:]

MARSP Michigan Association of Retired School Personnel
Protecting your future

President, Donald E. Miller
Executive Director, Bonnie J. Carpenter
PO Box 29214 • Lansing, MI 48909-8214
Office Hours:
7:30 a.m. - 11:30 a.m.
12:00 noon - 4:00 p.m.

Telephone: 517/337-1757 • Fax: 517/337-8560 • E-mail: staff-marsp@marsp.org • Home Page: www.marsp.org

May 21, 2007

The Honorable Dave Camp
Ranking Member
Committee on Ways and Means
Subcommittee on Health
1139E Longworth House office Building
Washington, DC 20515

Dear Representative Camp:

Thank you and your aide, Dan, for asking for our opinion on the Congressional talks regarding the 2008 budget for Medicare Advantage.

We are writing to ask for your support of continued Medicare Advantage funding and for you to encourage your peers to do so as well. Our organization was established in 1951 to support education in Michigan and to assist public school retirees with pension and health benefit issues. Approximately 115,000 of those retirees recently enrolled in a "Private Fee for Service Medicare Advantage Plan" and now depend upon adequate funding of the program.

While the program has some growing pains, there are a number of significant advantages coming forth:

- The program has brought increased simplicity. Retired school employees previously had to deal with the confusion of coordinating Medicare with a supplemental plan. It was not unusual for our retirees to get caught in the middle with resultant increase in out-of-pocket expenses. Worse yet, there have been known instances of retirees not obtaining necessary care because of the confusion. The Advantage program has resulted in a single identification card, a single payer of benefits and a single explanation of benefits for review and record-keeping.

- The program is bringing wellness and care management benefits to the retirees not previously available. These are benefits that ultimately may improve the quality of life for the retirees while resulting in fewer needed services. Seemingly a win/win program that would not be put in place if it were not for the Advantage program. If funding is reduced for the program, it will almost certainly reduce the availability and effectiveness of these important programs.

- Perhaps most importantly to education here in Michigan are the savings that will accrue to our public schools. You are well aware of the difficult budgetary times we are facing. The Advantage program is providing significant savings to the public schools. Savings that would be impossible to match in any other way other than to reduce coverage for much needed medical services for the retirees or to reduce funding for classroom efforts at educating our children.

Our organization is aware of discussions to reduce funding for the Advantage program, even before sufficient experience has been gained to know whether a decentralizing of authority and responsibility will ultimately deliver care to our seniors with increased efficacy and at a reduced cost. We ask that you and your peers oppose any cuts to the current Advantage program and give it a chance. Our retired public school employees here in Michigan are depending upon you.

Very truly yours,

Bonnie J. Carpenter
Executive Director

Donald E. Miller
President

cc: MARSP Board of Directors

Chairman STARK. Thank you.

I know that in introducing the first panel, Mr. Kind wanted to be here to introduce Commissioner Dilweg, the Insurance Commissioner of the State of Wisconsin. He was unavoidably detained, and I hope that Mr. Dilweg will accept the introduction from one who was born in Wisconsin and goes back for an occasional wake and wedding.

We are happy to have you. We are happy to have Ms. Patricia Neuman, who used to be with our staff, who is now Vice President of the Henry J. Kaiser Family Foundation. She is director of the Medicare Policy Project.

Mr. David Lipschutz of the California Health Advocates of Los Angeles. Welcome.

Mr. Brock Slabach, the Administrator of the Field Memorial Community Hospital from Centreville, Mississippi, who is here on behalf of the National Rural Health Association. Welcome.

The last member of the panel, I would yield to my friend Mr. Camp for the introduction.

Mr. CAMP. Thank you, Mr. Chairman. Thank you for the opportunity to introduce Ms. Catherine Schmitt, Vice President of Federal Programs with Blue Cross Blue Shield of Michigan. Blue Cross Blue Shield of Michigan is the largest insurer in the state and has touched the lives of nearly every Michigan resident.

I look forward to hearing from Catherine about Blue Cross Blue Shield's efforts to provide affordable options in the Private Fee-for-Service market and how it has worked with unions, businesses, and individuals on these innovative policies. Ms. Schmitt, thank you. Welcome to the Committee.

Thank you, Mr. Chairman. I yield back.

Chairman STARK. Thank you. Commissioner, would you like to lead off?

STATEMENT OF SEAN DILWEG, COMMISSIONER OF INSURANCE, STATE OF WISCONSIN, MADISON, WISCONSIN

Mr. DILWEG. Thank you, Chairman Stark—and I will accept your introduction any time—and Members of the Subcommittee. I appreciate you taking interest in this important issue.

My name is Sean Dilweg, and I am Commissioner of the Wisconsin Office of the Commissioner of Insurance. Thank you for inviting me here to share with you some observations on MA Private Fee-for-Service plans as the Insurance Commissioner of my home state.

I also currently serve as Chairman of the Senior Issues Task Force of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators from 50 states, the District of Columbia, and five U.S. territories. Although I am not testifying in my NAIC capacity, I would like to supplement some of my views with the collective views and experiences of our Nation's insurance commissioners on today's topic.

This afternoon, I will highlight marketing abuses experienced by Wisconsin consumers participating in MA programs, as well as those my fellow commissioners have seen across 43 states. I will demonstrate the limitations we are experiencing in protecting this vulnerable population from high pressure and unethical sales tac-

tics. in addition, I will propose a Medigap regulatory model as one solution to the problem that seniors are facing under this program.

First of all, we have begun to see a slew of marketing complaints over the last year. Initially, my office was created in our state constitution in Wisconsin to protect consumers and promote healthy insurance markets. State insurance commissioners and regulators are on the frontlines of consumer protection when it comes to private health insurance, and our departments receive complaints every day from our citizens.

Annually in Wisconsin we receive over 8,000 complaints across all insurance lines. We take each complaint very seriously. Wisconsin's insurance complaint process requires companies to respond to complaints within ten working days and to my office 10 days thereafter. On average, a case is closed within 40 days.

The insurance departments receive a whole spectrum of consumer complaints about the Medicare Program. Since January 1, 2006, my department has received approximately 400 complaints about marketing and sales problems involving MA and Medicare Part D prescription drug plans. I want to emphasize that this is only after 1 year, and if this is the baseline and if it continues with this trend, we are in trouble.

The NAIC has surveyed the experience of all members to date, and has received responses from 43 of the 50 states. The striking similarities to problems I have seen in Wisconsin to those of other states indicate troubling patterns and trends. Complaints listed were pervasive throughout the states:

Complaints about inappropriate or confusing marketing and sales practices leading seniors to enroll in a MA plan without adequately understanding their choice, or even knowing that they had been moved out of traditional Medicare.

Complaints about cross-selling, where insurance agents and brokers use Medicare Part D as a pretext to simply get in the door with a senior, a situation not prohibited by Medicare marketing guidelines. Once inside, agents instead sell the senior an unrelated and sometimes unsuitable insurance product.

Then across all states surveyed, we have consistently reported other types of complaints of high-pressure sales tactics that could be considered unethical at best and fraud at worst; sales by unlicensed agents and brokers; agents improperly portraying that they were from "Medicare" or Social Security in order to gain people's trust; seniors who merely asked for more information about a plan, or filled out a sign-in sheet at a health fair, to later discover they had been disenrolled from their own plan and enrolled in a new plan without their consent. Mass enrollments and door-to-door sales at senior centers, nursing homes, and assisted living facilities have also been seen.

I believe the driving force behind the confusion and misrepresentation in the market today is money—not the cost of the product, but what the companies and the agents can make selling the product. MA plans are reimbursed at an amount significantly higher than the cost of original Medicare. I have read of reimbursements being 111 to 113 percent or more of original Medicare, with Private Fee-for-Service plans receiving as much as 119 percent of original Medicare costs.

This translates to substantial additional costs and financial stresses to the Medicare Program. For example, in 2005, the Medicare Payment Advisory Commission noted that MA plan payments exceeded average local original Medicare fee-for-service costs by more than $5.2 billion, $1 billion alone in the state of California. As long as the profit potential for plans and the reimbursement to agents is so high, the marketing and the sales abuses, in my opinion, will continue.

We currently have limited state regulatory authority over these plans. Under other circumstances, the types of marketing practices I have described are either prohibited by state law as unfair or deceptive practices, or would be questioned by watchful state regulators.

However, these cases involve MA plans. The hands of the state regulators are often tied because we have lost all meaningful regulatory authority over MA plans, except for the licensure and solvency, as a result of Federal preemption.

I have included a table on page 6 of my written testimony to demonstrate the limitations we face in protecting MA consumers. You will notice that my department has all the tools we need in our tool kit to prevent the abuses I have described. We simply lack the authority to utilize them to monitor and take corrective action against a company for misconduct.

To be very clear, the states do have regulatory authority over insurance agents and brokers selling Medicare Private Fee-For-Service Plans. With this authority, my department, with limited resources, is acting aggressively against rogue agents.

However, without any ability to regulate the plans, I and other commissioners are limited in our ability to prevent sales and marketing abuses. We currently cannot hold the companies selling MA plans responsible for the acts of their agents, thereby severely restricting our ability to respond to inappropriate agent conduct. We do successfully utilize this authority in regulating other insurance markets. In the end, the agent is just that, an agent of the company.

My suggestion to you, Chairman Stark, and your Subcommittee as you work to improve the MA program would be to closely examine the Medigap regulatory model as one potential solution to the problems I have outlined today.

Medigap is a proven successful example of shared state/Federal regulation of a Medicare-related product that works well. It is popular with our seniors today. Given the opportunity by Federal law, the NAIC worked with CMS, industry representatives, consumer advocates, and other interested parties to establish a model regulation that included standardized benefits, benefit plan design, and regulatory standards for all Medigap plans. CMS and the NAIC continue to work together in ensuring the consumer protections under this model.

Additionally and very importantly, the Medigap model will provide people with greater stability and consistency in their health insurance plans from year to year. Wisconsin alone has 92 MA plans, 50 of which are Private Fee-for-Service, and over 50 Medicare Part D prescription drug plans offered by 22 companies.

Let me say that these products are some of the most complicated we have seen. As I review our complaints, I see sons and daughters with PhDs and legal degrees struggling to navigate these products for their parents. Simplified plans under the Medigap model allowed beneficiaries to compare plans and costs, and thereby make educated buying decisions. Adoption of this model will allow the same to be true for consumers shopping for MA and prescription drug plans.

In conclusion, in order for these programs to be successful and to truly be valuable to senior citizens, these issues need to be addressed as soon as possible. The baby boomers will hit the market in full force by 2010. The fastest growing segment of our population is seniors over 85.

I look to you for action, and I hope we can work together with Congress, state regulators, CMS, the insurance industry, agent groups, and consumer groups to provide seniors with products they can utilize and the protection they deserve.

Once again, thank you, Chairman Stark and the rest of the Subcommittee, for this opportunity to testify.

[The prepared statement of Mr. Dilweg follows:]

Statement of Sean Dilweg, Commissioner of Insurance, State of Wisconsin, Madison, Wisconsin

Good morning Chairman Stark, Ranking Member Camp, and members of the Subcommittee. My name is Sean Dilweg and I am Commissioner of the Wisconsin Office of the Commissioner of Insurance. Thank you for inviting me here to share with you some observations on Medicare Advantage Private Fee-for-Service Plans as Insurance Commissioner of my home state of Wisconsin. I also currently serve as chairman of the Senior Issues Task Force of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators from 50 states, the District of Columbia, and five U.S. territories, and although I am not testifying in my NAIC capacity today, I would like to supplement some of my views with the collective views and experiences of the nation's insurance commissioners on today's topic.

Marketing Complaints:

The primary objective of state insurance regulation is to protect consumers and promote healthy insurance markets. State insurance commissioners and regulators are on the front lines of consumer protection when it comes to private health insurance, and our departments receive complaints every day from our citizens. In about one-third of the states, the State Health Insurance Assistance Program (SHIP) is housed within the department of insurance.

In this role insurance departments receive the whole spectrum of consumer complaints about private Medicare programs, including Medicare Advantage and Medicare Part D. In many instances, the consumer complaints are routine, and to be expected for these large and complex programs. However, I would like to share with you an issue that has become of growing concern to me and other state insurance regulators, which is abuse in the marketing and sales of Medicare Advantage plans.

Although this issue is not limited just to Medicare Advantage Private-Fee-For-Service plans, the problems that insurance commissioners have seen in the states are often most evident when it comes to this product because of the tremendous rate of growth in the sales and enrollment in these plans. It has been reported that Private-Fee-For-Service Plans made up 46% of the total enrollment growth from 2005 to 2006.

Since January 1, 2006 my department has received approximately 400 complaints from consumers about marketing and sales involving Medicare Advantage plans. This is an extraordinarily high number. The complaints I have heard from Wisconsin consumers and in insurance departments across the country too often fall along familiar lines. The NAIC has surveyed the experiences of departments across the country, and the striking similarities to problems I have seen in Wisconsin indicate troubling patterns.

37 out of 43 state insurance departments have reported receiving complaints about inappropriate or confusing marketing practices leading Medicare beneficiaries to enroll in a Medicare Advantage plan without adequately understanding their choice to remain in traditional Medicare or without adequate understanding of the consequences of their decision. Beneficiaries believed they were signing up for a Medicare Part D stand-alone drug plan or a Medigap plan to supplement their traditional Medicare, but instead they were enrolled into a Medicare Advantage plan. Too often we find that the beneficiary did not know that he or she made this choice, or that he or she was not made aware of the implications of this decision, such as the fact that they would be giving up traditional Medicare, their Medigap policy, and also potentially restricting their access to doctors and other providers. We have heard instances when a beneficiary continues to send in their Medicare supplement premium for several months after they've signed up for a Medicare Advantage plan. In the most troubling of these cases, unscrupulous agents have enrolled beneficiaries with dementia into an inappropriate plan.

39 out of 43 state insurance departments have reported that they have received complaints about misrepresentations and inappropriate marketing practices. This includes instances where a plan or an agent provides inaccurate or misleading information about the provider network associated with a certain plan, or the benefits that the plan offers, or the beneficiary cost-sharing involved. This seems to be a particular problem with Medicare Private Fee-for-Service plans where seniors are being told that they can go to any provider who accepts Medicare without being told that, in order to be covered by the plan, the provider must have also have agreed to accept the plan's payments. States have also reported that agents are describing Medicare Advantage plans as "supplement" plans with extra benefits, thereby confusing the beneficiary into believing they are buying a Medigap plan to supplement traditional Medicare, when in fact they are enrolling in a Medicare Advantage plan.

31 out of 43 state insurance departments have also reported cross-selling, where insurance agents and brokers use Medicare Part D as a pre-text to get in the door with a senior, a situation that is not prohibited by the Medicare marketing guidelines.[1] Once inside, agents instead sell the senior an unrelated and sometimes unsuitable insurance product—including Medicare Advantage plans, annuities, life insurance policies, funeral policies, and other types of products. These other products are often much more lucrative to the agent than a Medicare Part D plan.[2] In Wisconsin, one insurer paid agents a commission of $50 for a Part D sale, whereas the commission for a Medicare Advantage sale was $250. With these types of financial incentives, inappropriate steering of beneficiaries to Medicare Advantage is difficult to avoid.

States have consistently reported other types of complaints of high-pressure sales tactics and tactics that could be considered unethical, at best, and fraud at worst:

- door-to-door sales;
- sales by unlicensed agents/brokers;
- agents improperly portraying that they were from "Medicare" or from "Social Security" in order to gain people's trust;
- seniors who merely asked for more information about a plan, or filled out a "sign-in sheet" at a health fair, and later discovered that they had been disenrolled from their old plan and enrolled in a new plan without their consent;
- mass enrollments and door-to-door sales at senior centers, nursing homes, or assisted living facilities;
- inappropriate use of gifts or gift cards as enrollment incentives;
- forged signatures on enrollment forms;
- improper obtainment or use of personal information.

These marketing concerns compound the difficulty consumers already face with these confusing programs, but are inherently acceptable under the Medicare Modernization Act of 2003 (MMA), and are exacerbated by troublesome and aggressive marketing tactics.

Limited State Regulatory Authority:

Under other circumstances, the types of marketing practices I've described are either prohibited by state law as unfair or deceptive practices in the business of insurance or would be questioned by watchful state regulators and controlled by the state regulatory structure. However, since these cases involve Medicare Advantage plans, or Medicare Part D, the hands of state regulators are often tied, as states are large-

[1] CMS Medicare Marketing Guidelines, pages 112–113.
[2] CMS Medicare Marketing Guidelines, pages 131–132.

ly pre-empted from regulating Medicare Advantage plans. The marketing guidelines are established by CMS, and, thus, a large regulatory gap exists in the regulation of these plans.

Since MMA, state regulators have lost all of their regulatory authority over Medicare Advantage plans, except for licensure and solvency. Prior to MMA states shared some regulatory oversight over Medicare Advantage plans, but the MMA scaled back on the ability of state insurance regulators to set or regulate marketing and sales standards for Medicare Advantage plans, and instead limited state regulation of Medicare Advantage plans to licensing and solvency. The MMA also established the same limited boundaries of state regulation for Medicare Part D plans.

This means that, unlike Medicare Supplement insurance or other types of state-regulated health insurance, the state insurance commissioner has very limited authority over the actual insurance company. In Medicare Advantage and Medicare Part D a state insurance department has no say in whether a marketing strategy or practice (such as permitting cross-selling or cold-calls) or advertisement is appropriate for this often-vulnerable population. We have limited ability to monitor companies in the marketplace and limited ability to take corrective action against a company for misconduct.

In the absence of such constraints imposed by the MMA, state regulators could prevent and react to such consumer problems by effective state regulation. A good example is Medicare Supplement insurance, which is also a Medicare-related product. States typically require companies to file their marketing plans and strategies with state regulators so that they can be reviewed prior to their use in the marketplace. State insurance commissioners also conduct market conduct reviews to ensure that consumer needs are being protected and they order corrective action if necessary. These are tools that are not available to us under Medicare Advantage and Medicare Part D, and I believe that there is a direct link to this inability for states to regulate and monitor this marketplace and the types of rampant abuses we are seeing today.

States' Regulatory Authority	Medigap	MedicareAdvantage	MedicarePart
Evaluation of Market Conductof Plans	YES	NO	NO
Enforcement of Benefit requirements, Enrollment, Eligibility, consumer protections, claims practices	YES	NO	NO
Evaluation of Network Adequacy	YES (Select plans)	NO	NO
Review and Approval of Policy Forms, rates, loss ratio compliance	YES	NO	NO
Regulation of Company Marketing, Sales, Advertising	YES	NO	NO
Regulation of Agent Conduct	YES	YES	YES
Ability to Address Consumer Complaints	YES	LIMITED	LIMITED

State Efforts:

To be clear, states do have regulatory oversight and authority over insurance agents and brokers, including those that sell Medicare-related products, including Medicare Private-Fee-For-Service plans. With this authority, I and my colleagues are acting as aggressively we can, with our limited resources, against rogue agents and brokers to the best of our ability. However, without the ability to regulate the plans themselves, state regulators are very limited in their ability to *prevent* the abuses that I've described earlier, and we can only act on the extraordinarily high number of complaints that *result* from these abuses. Most state regulators do not have the resources to track down and respond to every inappropriate agent action. In order for me to do that I would have to increase my staff. In traditional insurance, I can deal with inappropriate agent action by holding the insurance company responsible for the acts of its agents and thereby having it supervise and discipline its agents. Under the Medicare Advantage regulatory model, I cannot hold the companies responsible for the acts of their agents thereby severely crippling my ability to respond to inappropriate agent conduct. It's like trying to protect our seniors with our arms tied behind our backs.

Additionally, our regulatory authority over agents and brokers has been limited by CMS' interpretation that states' appointment laws are preempted by the federal law. We were very encouraged to hear at last week's hearing held by the Senate Special Committee on Aging that CMS is willing to re-examine its interpretation of its position of agent appointment laws. By not allowing states to enforce their appointment laws, it becomes virtually impossible for state regulators to track which agents sell Medicare Advantage products for the Medicare Advantage plans.

Also, due to the regulatory gap in oversight, in many instances state departments of insurance have not always received consumer complaint information about agent or broker misconduct. To remedy this situation, the NAIC has negotiated and finalized a Memorandum of Understanding (MOU) to be signed by state departments of insurance and CMS, so that they can share compliance related information between state and federal regulators. Since December, over 20 states have signed a separate MOU, and the NAIC is working with CMS to develop implementation procedures. In addition to agent/broker complaints, state departments of insurance and federal regulators hope to exchange information about enforcement actions, corrective actions, and other compliance related information. I hope that CMS will continue to make implementation of the MOU a high priority, and get states the information we need in a timely way so that we can act quickly to protect consumers against unscrupulous agents and brokers.

Even once the MOU is fully operational, state regulators are still very limited in their ability to prevent marketing and sales abuses. The preemption of state authority over the operations of Medicare Advantage plans—except licensure and solvency—means that consumers must go to CMS for assistance, regardless of the fact that state regulators have a closer connection to their citizens, more dedicated resources, and greater expertise in dealing with insurance consumer complaints than CMS. Despite these limitations, states continue to assist consumers to the best of their ability.

Financial Incentives:

Medicare Advantage plans are being reimbursed at an amount that is significantly higher than the cost of original Medicare. I have read of reimbursements between 111% to 113% or more of the cost of original Medicare with Medicare Advantage Private Fee-For-Service plans receiving 119% of the cost of original Medicare. In my opinion, these higher reimbursement amounts create financial incentives that may very well be a major cause for the marketing and sales abuses we are seeing today. Under the current reimbursement structure, companies have a very strong incentive to participate in the program and a very strong incentive to sign up as many enrollees as possible. In addition, because of the reimbursement structure, companies can provide generous remuneration to agents for enrolling as many people as possible.

It is my belief from what I have seen in my State and from many of my fellow commissioners these incentives have resulted in some significant harm to the Medicare-eligible as outlined earlier in my testimony. Some plans, and their agents and brokers, have used unacceptable sales and marketing techniques to sign up enrollees in their plans ignoring what is best for the enrollee. In the worst cases, marketing and sales tactics are used that are harmful to enrollees such as high pressure sales tactics, misleading and confusing marketing material, inappropriate sales, forged signatures, and more.

Another unintended result of these generous financial incentives is that plans may underestimate the utilization of the covered benefits so that they actually expe-

rience adverse financial results. This will occur if the bids submitted to CMS underestimate utilization and participation while at the same time include high expenses in acquiring business such as high agent commissions. The result is adverse financial performance forcing the plan to either get out of the market and thereby leaving its enrollees to find new and different coverage or change it's benefits and premiums so that the enrollees need to reevaluate whether the plan still meets their needs. Such a situation has recently been reported in Florida.

In order to address these problems, the incentives that cause them need to be addressed, along with leveling the playing field for the enrollee so that enrollee can make an educated buying decision. So long as the profit potential is as high as it is with these plans and the reimbursement to agents is so disproportionately high compared to Part D Prescription Drug Plans and Medigap policies, the marketing and sales abuses we are currently experiencing in Medicare Advantage, in my opinion, will continue.

Legislative Suggestions:

Chairman Stark, as you work to improve the Medicare Advantage program, I encourage this Subcommittee to closely examine this problem of the current regulatory gap over Medicare Advantage and Medicare Part D prescription drug plans. I believe that improving states' ability to exercise oversight over these plans is a key consumer protection that should be considered in any legislative efforts to improve this program, and I would like to offer a few specific suggestions.

Medigap as a model for improved plan regulation:

If Congress decides to continue to give seniors the choice to choose a private Medicare Advantage plan, including a Private Fee For Service Medicare Advantage plan, I would like to suggest that the Subcommittee look at the Medicare Supplement Insurance (or Medigap) regulatory approach as a potential model for improving these products. You may recall that federal action to standardize Medigap plans came about as a result of a history of rampant abuses targeting seniors in the marketplace throughout the 1980s. Many people have described the marketing and sales abuses that are currently occurring with Medicare Advantage plans as strikingly parallel to the abuses reported at that time before OBRA '90 was passed. From the Medicare beneficiary standpoint, Medigap is a proven successful example of shared state-federal regulation of a Medicare-related product that works well, and is popular with Medicare beneficiaries.

The most important aspect I believe you can take away from Medigap is the strong state regulatory authority. With Medigap, states have the ability to regulate both the agents *and* the companies in the marketing and sales of these products, as well as in other areas. We need this same ability to hold companies responsible for the acts of their agents in Medicare Advantage as we currently have for all other insurance products. If you eliminate this current regulatory gap, state insurance commissioners will have a greater authority and thereby greater ability to serve and protect their Medicare-eligible population, and consumers would be able to go directly to their state insurance departments to resolve problems, rather than having to call CMS who seems to have neither the manpower nor the expertise to deal with many of these types of complaints.

Now, I admit that I am speaking for my own state of Wisconsin on this recommendation. At the same time I know that every insurance commissioner is concerned with the current situation concerning these products that have caused all these problems in virtually every state. But, some commissioners may be wary of an unfunded mandate on the states to have a more active role in the regulation of these federally developed insurance products.

Medigap as a model for simplification:

I know that this Subcommittee is looking at a wide range of ideas to improve the Medicare Advantage program for beneficiaries. Therefore, I would like to take my suggestions one step further and suggest that you consider looking at the Medigap regulatory model for another reason beyond strong state regulation, which is to consider the concept of simplification of the benefits and benefit plan designs. As you might know, unlike Medicare Advantage or Medicare Prescription drug plans, the benefits for Medigap plans are standardized. This enables the consumer to make apples-to-apples comparisons so that they can make meaningful decisions.

Although Wisconsin is a relatively small, rural state, we have 92 Medicare Advantage plans 50 of which are Private Fee For Service Plans with premiums, in addition to the Medicare Part B premium, ranging from $-0—to $211 per month, and over 50 Medicare Part D prescription drug plans offered by 22 companies. Each plan has different benefit options, cost share, and formularies. Many of the problems I discussed earlier have occurred because these programs are simply too confusing for

people to understand. Medigap plans were simplified so that beneficiaries are able to compare plans and costs, and thereby make educated buying decisions. Under the Medigap model, beneficiaries have many choices of coverage. I have heard from our Medicare-eligible seniors that they or their children, some of whom are attorneys or PhD's, are unable to figure out all the various options under Medicare Advantage and Part D so that they can make a good decision for their coverage. Yet, with simplified and consistent benefits and benefit plan designs amongst the plans, beneficiaries are able to truly compare plans when making their buying decisions.

Medigap is a good model, because as a result of federal legislation and a partnership of state and federal regulators, we have made the product simpler for the consumer to understand and to compare plans, yet with many choices of coverage. The standardized benefits were set by CMS, in conjunction with the NAIC through a unique delegation from Congress. Given the opportunity by federal law, the NAIC worked with CMS, industry representatives, consumer advocates, and other interested parties to establish a Model regulation that includes benefit, benefit design and regulatory standards for all Medigap plans.

Medigap as a model for improved consumer protections:

In 2006, a major Medicare Advantage company offered several Private Fee-For-Service plans in Wisconsin. One of those plans, as an example, provided Medicare Part A and Part B coverage along with prescription drug coverage at no additional premium to the enrollee. The plan had a $180 per day hospital co-pay for the first 3 days of a hospital stay. After the third day the plan picked up all hospital charges. That same plan in 2007 now charges $39 per month additional premium and has changed its hospital cost-share to a $550 deductible for any hospital stay whether it is for one day or 30 days. The company informed its enrollees through the CMS approved plan amendment document. The plan document did not significantly highlight these reductions in coverage and increased premium in any way. In addition, to my knowledge, the company did not hold informational meetings with its beneficiaries to go over the changes to their plan during the open enrollment period. For many beneficiaries, the way they found out about the changes is when they got their premium payment coupons and if they went to the hospital.

That is one of the major problems with the Medicare Advantage plans. They can change the cost-share provisions and the premium annually so that the stability in coverage expected by the beneficiary is really not there. People are used to stability and consistency in their health insurance plans from year-to-year. Medicare Advantage does not provide that stability. This could not happen under the Medigap regulatory model, as Medigap plans are guaranteed renewable which means plans cannot unilaterally change coverage from year-to-year except to adjust to original Medicare's changes of its deductibles and co-payments Although premiums might differ slightly, the benefits for an individual beneficiary would not change. Plans could decide to offer a different set of benefits or plans for new enrollees, but they would not be able to disrupt the coverage they are already providing to insureds. I urge you to consider these types of key consumer protections.

Finally, a major problem with Medicare Advantage plans is that they do not provide the stability beneficiaries have with original Medicare and a Medicare supplement policy. This is because the plans have a one year contract with CMS which means that a plan can chose to leave a market at any time at the end of any year. This happened in the 90's when the then Medicare + Choice reimbursement formulae were changed. We have already seen it in 2007 when a major Medicare Advantage provider left certain markets forcing its enrollees to switch plans. Senior insurance consumers like stability. Under the current Medicare Advantage program they have none. Plans can change their benefits and cost shares every year and can abandon a market should they chose leaving their enrollees high and dry.

Summary:

In order for these programs to be successful and valuable to the market place, these issues need to be addressed with all dispatch. The baby boomers will hit the market in full force by 2010. The fastest growing segment of the population is the 85+ segment. I look to you for action and I hope we can work together; the Congress, state regulators, CMS, the insurance industry, the agents' groups, and the consumer advocates to provide our Medicare-eligible population with products they can compare, with marketing and sales standards that provide protection, yet allow for innovation, and an enforcement structure that provides assurance that they are protected.

Thank you again for this opportunity to testify today.

Chairman STARK. Thank you, Mr. Dilweg. I was going to—Mr. Kind is here, and I did allow as to how Mr. Dilweg would get an introduction by an old badger.

I neglected to mention that if he looks back in records, he might find that I once was licensed, I think in 1951, to sell life insurance in the state of Wisconsin, but I am sure you are much better at regulating who gets licenses now than you were then, and I hope that you have improved your thorough investigation since then. You did mention——

Mr. DILWEG. I will have to pull your file.

Chairman STARK [continuing]. The Medigap legislation. It is interesting that the lady sitting to your left was on the staff when that was drafted and had her hand in that. With that, we will hear from Ms. Patricia Neuman.

STATEMENT OF PATRICIA NEUMAN, Sc.D., VICE PRESIDENT, HENRY J. KAISER FAMILY FOUNDATION, DIRECTOR, MEDICARE POLICY PROJECT

Dr. NEUMAN. Thank you, Chairman Stark and Mr. Camp and distinguished Members of the Committee. I appreciate being invited to come here and talk to you today about Private Fee-for-Service plans.

Private Fee-for-Service plans currently enroll 3 percent of the total Medicare population, or about 1.5 million beneficiaries. CBO projects enrollment levels will double within 2 years and nearly triple within ten. This increase is notable for many reasons, not the least of which is that MedPAC, CBO, and the Department of Health and Human Services (HHS) Office of the Actuary report that the shift in beneficiaries from traditional Medicare to MA plans, including Private Fee-for-Service, will increase Medicare spending.

Despite initial skepticism about the need for or viability of Medicare Private Fee-for-Service plans, all beneficiaries today have the option to enroll in one or more Private Fee-for-Service plans, and half can choose among six or more firms offering a Medicare Private Fee-for-Service option, and many of those firms offer multiple plans.

At this point, little is known about the characteristics of Medicare beneficiaries who are enrolling in Private Fee-for-Service plans other than where they live. We know that about 40 percent are living in rural areas, and the majority, or about 60 percent, are in urban areas.

Nationwide, about 5 percent of all beneficiaries living in rural areas are in Private Fee-for-Service plans, compared to about 3 percent of that enrollment for all Medicare beneficiaries. More information is clearly needed to understand the characteristics and needs of beneficiaries who enrolling in various types of MA plans.

Private Fee-for-Service plans operate under a different set of rules and requirements than the other MA plans, and this creates an unlevel playingfield for other plans, and it also creates some uncertainty for beneficiaries.

Private Fee-for-Service plans are not required to provide the Medicare drug benefit, as others must. Those that do not provide a drug benefit are permitted to enroll beneficiaries from traditional

Medicare throughout the calendar year for 2007 and 2008, while others are constrained by the more standard open enrollment period. Private Fee-for-Service plans are not required to report quality measures, as other plans do.

Private Fee-for-Service plans are exempt from a provision of the law that allows the Secretary to negotiate bids and extra benefits, or supplemental benefits, with MA plans, and that also is unlike the requirements that pertain to MA plans.

I want to focus for the next few minutes on issues that have emerged which could have important implications for beneficiaries, the first of which has to do with out-of-pocket spending and benefits. Many Private Fee-for-Service plans waive deductibles, offer stop-loss and catastrophic spending, and provide additional benefits such as help with eyeglasses or dental care or other benefits.

Even with these additional benefits, sicker beneficiaries could face higher cost-sharing requirements under Private Fee-for-Service plans than under traditional Medicare. For example, some Private Fee-for-Service plans impose daily copays on hospital stays or on home health visits, unlike traditional Medicare. These daily fees can add up. Only about half of Private Fee-for-Service plans offered a drug benefit in 2006, and none of the plans with a drug benefit covers brand-name drugs in the coverage gap.

With extra benefits, some beneficiaries can spend less than they otherwise would, but my written statement illustrates how a not very atypical and hypothetical beneficiary could end up paying more under Private Fee-for-Service plans than under traditional Medicare. It also illustrates the wide variations in benefits and cost-sharing that can be seen in Private Fee-for-Service plans that seniors may encounter. This could make it quite difficult for a beneficiary to compare plans when they go about making choices so they can understand the value of the different plans that are available to them.

A second issue relates to access to medical providers. A key idea behind the idea of Private Fee-for-Service was that beneficiaries would have unfettered access to medical care in contrast to more managed care types of Medical Advantage plans.

However, providers are not required to accept Private Fee-for-Service enrollees even if they accept other Medicare patients. Since plans do not have contractual obligations with providers, they are unable to guarantee enrollees access to physicians, specialists, or other medical providers. Efforts to educate providers may be helpful over time, but in the short term, decisions by some doctors and or health care providers to refuse to see Private Fee-for-Service patients may come as an unwelcome surprise to seniors who elected the plan under the impression that they could be treated by virtually any provider.

A third issue, as you have heard already, relates to marketing practices, a particular concern given the vulnerabilities of so many Medicare beneficiaries, particularly the 25 percent with cognitive impairments. These marketing practices are likely to compound the underlying confusion that we have observed in our research and studies by others that show that seniors are very unclear about very basic differences between MA and traditional Medicare. It is quite easy to see how seniors would be challenged to understand

the difference between Private Fee-for-Service Medicare plans and traditional fee-for-service Medicare.

Last, an overlooked aspect of the MA program and its current payment system is the effect on beneficiaries in traditional Medicare. Again, according to the HHS Actuary, beneficiaries who pay a monthly part B premium pay an additional $2 a month to help finance additional payments to MA plans. These costs are borne by an estimated 29 million beneficiaries on the program.

With just 3 percent of all beneficiaries enrolled in these plans, but a growing number of beneficiaries migrating to them, now may be the time to address key issues that have significant implications for beneficiaries, for taxpayers, and for the Medicare Program itself. Thank you very much.

[The prepared statement of Dr. Neuman follows:]

Statement of Patricia Neuman, Sc.D., Vice President, Henry J. Kaiser Family Foundation, Director, Medicare Policy Project

Chairman Stark, Mr. Camp, distinguished members of the Committee, thank you for inviting me here today to discuss Medicare Advantage Private Fee-for-Service plans. I am Patricia Neuman, a Vice President of the Kaiser Family Foundation and Director of the Foundation's Medicare Policy Project.

Medicare Private Fee-for-Service plans are one among many private plan options offered to beneficiaries under the Medicare Advantage program. As with other types of Medicare Advantage plans, Medicare Private Fee-for-Service plans are offered by health insurance companies that receive capitated payments from Medicare to provide health benefits for each Medicare enrollee. My testimony draws on a number of studies commissioned and conducted by the Kaiser Family Foundation, as well as other reports. This testimony reviews the role of Private Fee-for-Service plans under Medicare; examines how Private Fee-for-Service plans differ from other Medicare Advantage plans; and discusses key issues for beneficiaries and long-term implications for Medicare.

Why Focus on Medicare Private Fee-for-Service Plans

Over the past two years, Medicare Private Fee-for-Service plans have grown much faster than many expected, and recently we have seen signs of growing pains. We have heard and read reports about aggressive marketing practices, confused beneficiaries, and doctors and hospitals refusing to see patients who are enrolled in Private Fee-for Service plans. MedPAC, the Congressional Budget Office and the HHS Office of the Actuary are in agreement that the shift of beneficiaries from traditional Medicare to Medicare Advantage plans increases Medicare spending, leading others to raise concerns about whether the Private Fee-for-Service plan option provides adequate value to beneficiaries and taxpayers.

Private Fee-for-Service plans collectively enroll a very small share (3 percent) of the total Medicare population and less than 20 percent of all Medicare Advantage enrollees, yet their role in the Medicare program has emerged as a front-burner issue (Exhibits 1 and 2).

First, there has been a rapid increase in the number of beneficiaries enrolling in Private Fee-for-Service plans since 2005 (Exhibit 3). Private Fee-for Service plans were first authorized in 1997, but received minimal attention with enrollment hovering at about 25,000 enrollees. Today, 1.5 million Medicare beneficiaries are enrolled in Private Fee-for-Service plans, up from 209,000 in 2005. CBO projects that enrollment levels will double within two years, and nearly triple within ten years, and projects that this jump in enrollment will lead to an increase in Medicare spending as beneficiaries shift from traditional Medicare to Medicare Advantage plans (Exhibit 4).

Second, Medicare pays more for Medicare Advantage enrollees, on average, than it would pay for the same beneficiaries in traditional Medicare. Medicare pays, on average, 12 percent more for beneficiaries who enroll in Medicare Advantage plans than it would pay for the same individuals to be covered under the traditional Medicare program, and pays 19 percent more, on average, for beneficiaries who enroll in Private Fee-for-Service plans, according to MedPAC (Exhibit 5). Medicare's payments do not vary by type of Medicare Advantage plan, but are higher for Private Fee-for-Service plans because the counties in which they operate tend to have high payments relative to costs (MedPAC, 2007; Gold, 2007a).

Third, Private Fee-for-Service plans operate under a different set of rules and requirements than other Medicare Advantage plans (Blum, 2007). Firms that offer Private Fee-for-Service plans are not required to provide a plan with a Medicare Part D drug benefit, nor are they required to have quality and utilization review and reporting procedures. They are also exempt from a provision that allows the Secretary to negotiate monthly bid amounts and supplemental benefits with plans, unlike other Medicare Advantage plans (Exhibit 6).

Furthermore, unlike other Medicare Advantage plans, Private-Fee-for-Service plans are not required to establish networks of physicians, hospitals and other providers—and most have elected to operate without a network. This makes it easier for Private Fee-for-Service Plans to enter the market, but the downside for enrollees is that, without contractual relationships, Private Fee-for-Service plans are unable to guarantee access to physicians and other providers for their enrollees, and have limited ability to coordinate or manage care.

A recent legislative change gives certain Private Fee-for-Service plans a leg up in growing market share by allowing plans that do not provide the Part D drug benefit to enroll beneficiaries who are in traditional Medicare throughout the entire calendar year in 2007 and 2008, rather than in the more limited existing open enrollment period that applies to other plans.

The Current Medicare Private Fee-for-Service Landscape

Despite initial skepticism about the need for or viability of Medicare Private Fee-for-Service plans, dozens of companies are currently offering these plans throughout the country (Gold, 2007b). All beneficiaries now have the option to enroll in one or more Private Fee-for-Service plans, and half of all beneficiaries (52 percent) can choose among six or more firms offering a Medicare Private Fee-for-Service option (Gold, 2007b). In some areas, such as Madison County, Wisconsin, beneficiaries can choose from among 27 Medicare Advantage plans, 19 of which are Private Fee-for-Service plans offered by five different firms.

From an insurer's perspective, there are a number of features of Private Fee-for-Service plans that make them appealing, relative to other Medicare Advantage plans. Unlike Regional Preferred Provider Organizations (PPOs) which were authorized under the Medicare Modernization Act of 2003, Private Fee-for-Service plans are permitted to operate at the county level, rather than serve an entire region, giving firms the flexibility to strategically pursue new enrollees in relatively high payment areas. However, unlike other Medicare Advantage plans that operate at the county level, such as HMOs, Private Fee-for-Service plans are not required to establish a network of providers, which eases the administrative burden of market entry and reduces start-up costs. In addition, firms that currently offer Medigap policies may see Medicare Private Fee-for-Service plans as an attractive alternative for their Medigap policyholders, because they can now offer a government-subsidized source of supplemental coverage that could help reduce the monthly premiums they charge.

Looking to the future, some believe that Private Fee-for-Service plans will become more popular among employers who offer health benefits to Medicare-eligible retirees. Private Fee-for-Service plans that have no provider network are uniquely positioned to provide coverage to retirees throughout the country. Currently, enrollment among retirees in employer plans represents a very small share of total Private Fee-for-Service enrollment because employers have been slow to take up this option. In fact, more than six of ten large private sector employers (62%) that offer benefits to age 65+ retirees said they did not offer a Medicare Advantage plan option in 2006 (Kaiser/Hewitt, 2006).

Characteristics of Beneficiaries in Private Fee-for-Service Plans

Little is known about the characteristics of beneficiaries who are choosing to enroll in Medicare Private Fee-for-Service plans, why they are enrolling, the services they receive or the extent to which they are able to see their doctors, specialists and other health care providers.

Private Fee-for-Service enrollees are spread throughout the country, with roughly three quarters of all enrollees coming from urban floor counties (such as Arlington, Virginia or Greensboro, North Carolina) and rural floor counties (MedPAC, 2007b). MedPAC also reports that the majority of Private Fee-for-Service enrollees live in urban areas and that about five percent of all beneficiaries living in rural areas are enrolled in a Medicare Private Fee-for-Service plan. In 2006, six states (GA, MI, MN, NC, VA, WI) had between 40,000 and 70,000 enrollees, while 12 states had fewer than 1,000 enrollees and another 14 states had between 1,000 and 10,000 Private Fee-for-Service enrollees (Gold, 2007b).

Given the absence of publicly-available data on the characteristics of Medicare Advantage enrollees, by plan type, it is not possible to paint a demographic picture of

the Medicare Private Fee-for-Service population, nor determine if beneficiaries enrolled in these plans are disproportionately vulnerable relative to enrollees in other Medicare Advantage plans or traditional Medicare. In general, Medicare Advantage plan enrollees tend to be in better health and have fewer chronic diseases than their counterparts in traditional Medicare, based on our analysis of the 2003 Medicare Current Beneficiary Survey. Medicare Advantage plans also enroll a smaller share of beneficiaries who are under age-65 who have permanent disabilities. As new data become available, it will be important to examine the characteristics of beneficiaries who are enrolling in various types of Medicare plans. However, there are currently no data available to determine whether Private Fee-for-Service enrollees differ from other Medicare Advantage enrollees in terms of medical needs or other characteristics, such as income or gender.

Key Considerations for Beneficiaries

Because Medicare Private Fee-for-Service plans are relatively new, and because they differ from other types of Medicare Advantage plans, beneficiaries have had little time to understand how they differ from the traditional fee-for-service Medicare program. A number of issues have emerged that have implications for beneficiaries.

Out-of-Pocket Spending and Benefits.

Many Private Fee-for-Service plans waive deductibles, offer a stop-loss limit on catastrophic spending for services covered under Parts A and B, unlike traditional Medicare, and also provide some additional benefits; however, even with these additional benefits, sicker beneficiaries could be disadvantaged by high cost-sharing requirements under Private Fee-for-Service plans relative to traditional Medicare (Gold, 2007a).

Unlike traditional Medicare, some Private Fee-for-Service plans impose daily hospital copayments, daily copayments for home health visits, and daily copayments for the first several days in a skilled nursing facility. Only about half of all Medicare Private Fee-for-Service plans offered a drug benefit in 2006, and none of these plans covered brand-name drugs in the so-called "doughnut hole" (Gold, 2007a).

To illustrate the potential for higher out-of-pocket costs under Private Fee-for-Service plans than traditional Medicare, consider three different Private Fee-for-Service plans offered in Madison County, Wisconsin for a hypothetical but not atypical elderly woman on Medicare (Exhibit 7).

Mrs. Rollins broke her hip, was admitted to the hospital for 8 days, then transferred to a skilled nursing facility (27 days) before going home and receiving home health visits to support her rehabilitation (47 visits). Mrs. Rollins would pay the monthly Part B premium under all three Private Fee-for-Service plans and traditional Medicare, and a supplementary premium under two of the Private Fee-For-Service plans. Under one of the plans, she would pay a supplemental premium of $99/month ($1,200/year) but would not get the Part D drug benefit.

Mrs. Rollins would pay $1,860 out-of-pocket in traditional Medicare, but $2,688, $2,710 or $3,519.50 under the three Private Fee-for-Service plans, taking into account the supplemental premiums and the stop-loss protection. Under the first plan, she would be helped by a $1,500 stop loss, but have higher costs due to the supplemental premium.

In other words, beneficiaries requiring a hospital stay and post-acute care, such as the hypothetical Mrs. Rollins, would pay more under each of the three Medicare Private Fee-for-Service plans than under traditional Medicare. This example also illustrates the wide range in out-of-pocket spending that beneficiaries may incur, depending on the plan they select. Beneficiaries could be hard-pressed to sort out these differences and others prior to enrollment in order to choose the least-costly plan for themselves.

Access to Physicians and Other Health Care Providers.

A central notion behind Private Fee-for-Service plans was that beneficiaries would have unfettered access to their medical providers, in contrast to more "managed" types of Medicare Advantage plans. However, providers are not required to accept Private Fee-for-Service enrollees—even if they accept other Medicare patients. There is mounting evidence from press reports that at least some beneficiaries enrolled in Private Fee-for-Service plans have been denied care by their medical providers (e.g. *Wall Street Journal*, May 8, 2007; *Tampa Tribune*, April 29, 2007)

It is not clear why some providers are refusing to treat patients who are enrolled in Private Fee-for-Service plans. Some have suggested that physicians are not familiar with the terms and conditions of Private Fee-for-Service plans, are wary of agreeing to see a patient without fully understanding how the plan works, and are concerned about administrative hassles. Other issues include concerns about payment levels and the amount of time it may take to get paid by such plans.

Efforts by Private Fee-for-Service plans to educate providers may address these issues over time, but in the short-term, providers' decisions to refuse to treat Private Fee-for-Service patients may come as an unpleasant surprise to seniors who elected this plan option under the impression that they could be treated by virtually any provider, just as they could under traditional Medicare. The fact that most Private Fee-for-Service plans do not have networks makes it difficult for beneficiaries to determine if their various doctors, specialists or even hospitals will accept a plan.

Questionable Marketing Practices.

In recent months, there have also been a number of reports and press accounts about aggressive, high-pressure marketing activities designed to lure beneficiaries into Medicare Advantage plans, including but not limited to Private Fee-for-Service plans. For example, a recent survey conducted by the National Association of Insurance Commissioners reports that 39 of 43 states received complaints about misrepresentations and inappropriate marketing practices, and 37 of 43 states reported that these practices led some beneficiaries to enroll in a Medicare Advantage plan without fully understanding the implications of their choice (Dilweg, 2007). These marketing activities are a particular concern, given the vulnerabilities of so many Medicare beneficiaries, including the roughly 25 percent of beneficiaries with cognitive impairments, such as Alzheimer's disease.

The concern, according to senior advocates and insurance commissioners, is that beneficiaries are finding themselves enrolled in Medicare Advantage plans in which they did not intend to enroll, and without a good understanding of how their plan operates. It is easy to see how a senior could be confused about the differences between traditional fee-for-service Medicare and Medicare Advantage Private Fee-for-Service plans, or confused about the different types of Medicare Advantage plans. These differences could have significant implications for beneficiaries' out-of-pocket spending and provider access.

Efforts to curb overly aggressive and misleading sales practices are critical, particularly given beneficiaries lack of understanding about the various types of Medicare plans (Hibbard, 2006).

Equity Concerns: Who Pays?

An often overlooked aspect of the Medicare Advantage program, and its current payment system, is the effects on beneficiaries who are covered under traditional Medicare. Because Medicare Advantage plans cover benefits under Medicare Parts A and B, the financing for Medicare Advantage benefits directly affects the Part A Trust Fund and Part B premiums.

According to the Office of the Actuary at HHS, the current payment system has the effect of cutting by two years the solvency of the Part A trust fund, potentially affecting coverage for current beneficiaries as well as pre-65 adults who are approaching the age of Medicare eligibility.

In addition, the HHS Actuary recently announced that the current payment system for Medicare Advantage plans has increased Part B premiums by an additional $2/month. These costs are borne by an estimated 29 million beneficiaries and by all states that contribute to Part B premiums on behalf of beneficiaries who are dually eligible for Medicare and Medicaid (Exhibit 8).

Summary

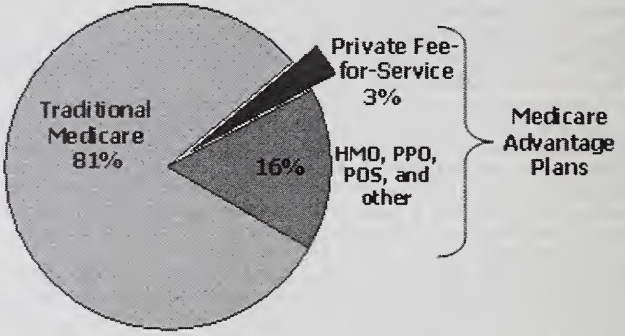
A review of Private Fee-for-Service plans reveals a number of issues for beneficiaries, taxpayers and the Medicare program itself. With about three percent of all beneficiaries enrolled today, and before a growing number of beneficiaries migrate to Medicare Private Fee-for-Service plans, now may be the time to focus greater attention on a number of issues that have surfaced.

Private Fee-for-Service plans have given more people on Medicare the option of choosing a private plan for their Medicare benefits, and have the potential to reduce enrollees' out-of-pocket costs. However, Private Fee-for-Service plans also have the potential to increase out-of-pocket costs for enrollees with serious health needs, and there is evidence that at least some patients enrolled in these plans have been denied care by physicians, specialists and other providers, despite expectations of unfettered access, similar to traditional Medicare.

With cost pressures facing Medicare and competing priorities for limited resources, serious issues for lawmakers to consider include whether Private Fee-for-Service plans offer value to Medicare constituents, and at what cost; whether Private Fee-for-Service plans should be exempt from requirements that apply to other plans; and whether sustaining current payment levels for Medicare Advantage plans is affordable, given the fiscal challenges that lie ahead.

EXHIBIT 1

Medicare Private Fee-for-Service Enrollment as a Share of the Total Medicare Population, 2007

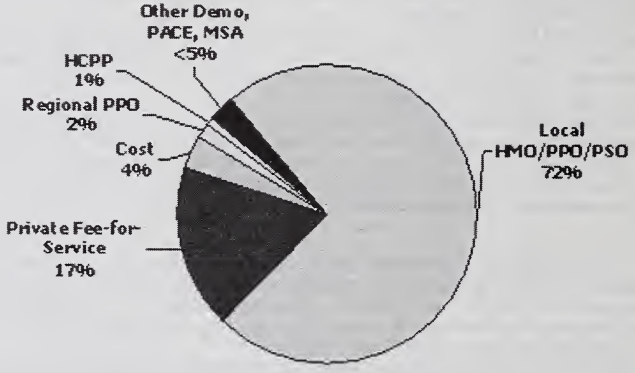


Total Medicare Beneficiaries = 44 million

SOURCE: Centers for Medicare and Medicaid Services, Medicare Advantage, Cost, PACE, Demo and Prescription Drug Plan Contract Report – Monthly Summary Report (Data as of May 2007).

EXHIBIT 2

Medicare Advantage Enrollment By Plan Type, 2007

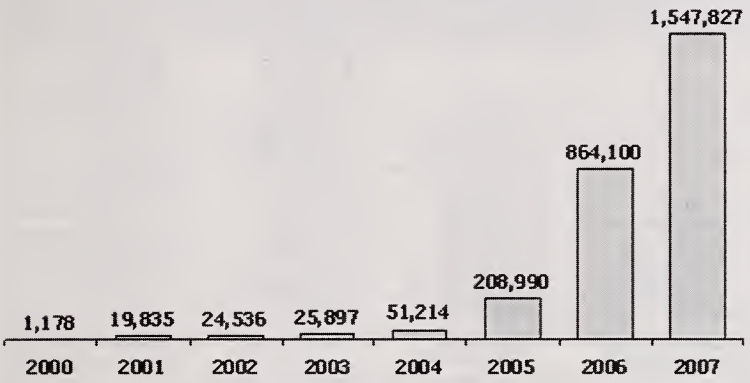


Total Medicare Advantage Enrollment = 8.6 million

SOURCE: Centers for Medicare and Medicaid Services, Medicare Advantage, Cost, PACE, Demo and Prescription Drug Plan Contract Report – Monthly Summary Report (Data as of May 2007).

EXHIBIT 3

Private Fee-For-Service Enrollment, 2000-2007

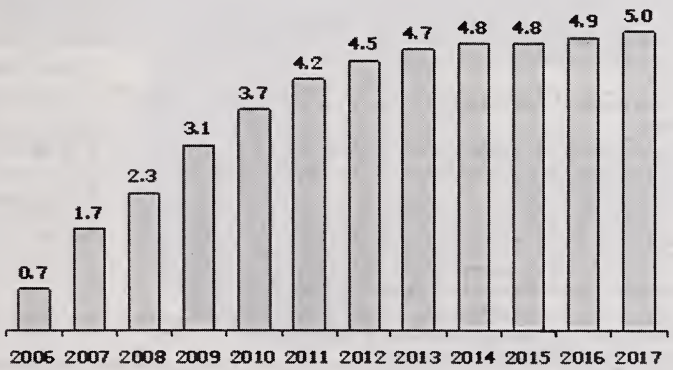


SOURCE: Avalere Health analysis of Centers for Medicare and Medicaid Services, Medicare Managed Care Contract Report (2000-2005); Centers for Medicare and Medicaid Services, Monthly Summary Report (2006-2007). Figures are year-end for 2000-2006 and as of May for 2007.

EXHIBIT 4

Current and Projected Enrollment in Medicare Private Fee-for-Service Plans, 2006-2017

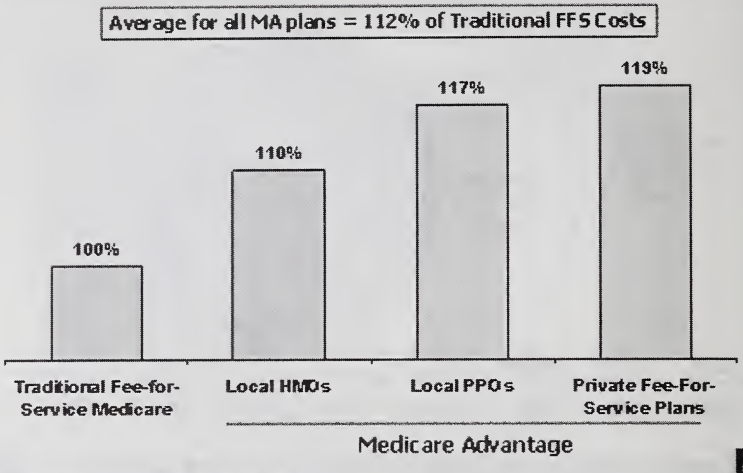
Enrollment Growth (in millions):



SOURCE: Congressional Budget Office, The Medicare Advantage Program: Enrollment Trends and Budgetary Effects, CBO Testimony, April 11, 2007.

Exhibit 5

Payments to Medicare Advantage Plans as a Share of Medicare Fee-for-Service Costs, 2006



Source: Medicare Payment Advisory Committee, March 2007.

Exhibit 6

Comparison of Selected Requirements for Non-Network Private Fee-for-Service Plans and Other Medicare Advantage Plans

Requirements	Network MA Plans (HMOs, PPOs)	Non-Network PFFS Plans
Plan must offer an MA plan that includes the Part D drug benefit	Yes	No
Plan must conduct baseline health assessment of new enrollees	Yes	No
Plan must identify and coordinate care of members with complex or serious medical conditions and arrange for necessary specialty care	Yes	No
Plan must conduct utilization review and develop mechanisms to detect under- and over-utilization	Yes	No
Plan must work with an independent quality review and improvement organization to perform external plan reviews	Yes	No
Plan must collect and report HEDIS data to assess and compare plan performance	Yes	No
CMS has authority to negotiate monthly bid amounts with plan, including supplemental benefits	Yes	No

SOURCE: Blum, Jonathan, Ruth Brown, and Miryam Frieder, "An Examination of Medicare Private Fee-for-Service Plans," for the Henry J. Kaiser Family Foundation, March 2007.

Exhibit 7

Comparison of Medicare Cost-Sharing Requirements in Traditional Medicare vs. Three Private Fee-for-Service Plans

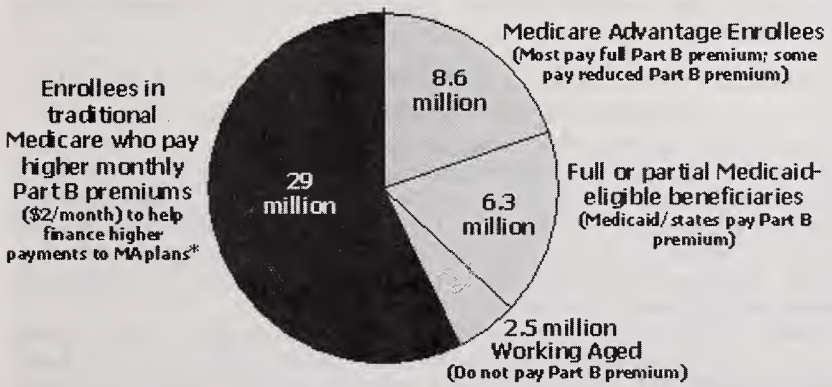
(Case Example: Madison, Wisconsin – zip code 53717)

COST-SHARING (Traditional Medicare)	Private Fee-for-Service Plans		
	SecureHorizons MedicareDirect Premier 300 (UnitedHealth)	Humana Gold Choice PFFS	Concert (Wellcare)
Monthly Premium (in addition to Part B $93.50/month)	$99	$0	$41
Inpatient Hospital Care ($992/deductible, coins. after 60 days)	$100/day for days 1-90	$550 copay for each hospital stay	$225/day days 1-5; $0/day days 6-90
Home Health (No Copayment)	$0	$0	$0 to $35 per day*
Skilled Nursing Facility ($0 days 1-20; $124 days 21-100)	$0 days 1-10; $115 days 11-100	$0 days 1-3; $90 days 4-100	$0 days 1-15; $90 days 16-60
OOP Limit (None)	$1,500/year	$5,000/year	$3,650/year
Rx Drugs (Access to Stand-Alone drug plans (PDPs))	No drug benefit	Drug benefit; No coverage in the doughnut hole	Drug benefit; No coverage in the doughnut hole

SOURCE: Medicare Run Rates, www.medicare.gov. * Case study assumes mid-point of $175/day

Exhibit 8

Distributional Impact of Higher Payments to Medicare Advantage Plans Relative to Traditional Medicare


Enrollees in traditional Medicare who pay higher monthly Part B premiums ($2/month) to help finance higher payments to MA plans*
29 million
8.6 million
Medicare Advantage Enrollees
(Most pay full Part B premium; some pay reduced Part B premium)
6.3 million
Full or partial Medicaid-eligible beneficiaries
(Medicaid/states pay Part B premium)
2.5 million Working Aged
(Do not pay Part B premium)

Total Number of Beneficiaries = 44 Million

NOTE: * Effect on Part B premium provided by HHS Office of the Actuary, 2007.

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Blum, Jonathan, Ruth Brown, and Miryam Frieder, "An Examination of Medicare Private Fee-for-Service Plans," Henry J. Kaiser Family, March 2007.
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Medicare Payment Advisory Commission. Presentation from Public Meeting, Washington, D.C., March 8, 2007b.

Chairman STARK. Thank you, Trish.

Mr. Lipschutz is the staff attorney for the California Health Advocates from Los Angeles. We know them in California as Health Insurance Counseling and Advocacy Program (HICAP). They provide advocacy services for Medicare and Medicaid beneficiaries. Welcome. Please enlighten us in any manner you are comfortable, Mr. Lipschutz.

STATEMENT OF DAVID A. LIPSCHUTZ, CALIFORNIA HEALTH ADVOCATES, LOS ANGELES, CALIFORNIA

Mr. LIPSCHUTZ. Thank you, Mr. Chairman. Good afternoon, Chairman Stark, Ranking Member Camp, and distinguished Committee Members. Thank you for giving me the opportunity to testify this afternoon. My name is David Lipschutz, and I am a staff attorney with California Health Advocates, an independent nonprofit organization dedicated to education and advocacy efforts on behalf of Medicare beneficiaries.

We do this in part by providing technical assistance and training to the network of state health insurance programs, known in California as HICAP. Our experience with Medicare is based in large part on our close work with the HICAPs and other consumer assistance programs that are on the front line assisting Medicare beneficiaries.

We recognize that MA plans can be a suitable option for some people with Medicare, but the recent dramatic rise in the availability of and enrollment in Private Fee-for-Service plans is a cause of major concern for Medicare beneficiaries because this rise has come with widespread and abusive marketing practices, as well as

serious access to care issues faced by many who are enrolled in these plans.

When we talk about marketing misconduct, it is not our intent to malign all agents selling Medicare products. We are in contact with a number of agents who we know are honest and aboveboard, but we take issue with the insurance industry and CMS blaming marketing problems on a "few bad apples." To the contrary, misconduct is occurring by the bushel load. If you will allow me to stretch a metaphor, the entire orchard is subject to rot as long as several underlying, systemic problems and issues remain.

These factors include a commission structure that typically pays agents up to five times the amount for each MA enrollment as opposed to each enrollment in a stand-alone prescription drug plan, which creates an incentive to steer individuals toward certain products regardless of whether such products are the most suitable choice for an individual consumer.

Also, lack of adequate oversight and training of agents by plans leaves many agents ignorant about the products they are selling and the impact that enrolling in these products might have on prospective enrollees, including potential loss of other types of insurance.

The numbers and types of abuses are many, and include Medicare beneficiaries being signed up for plans without their consent or knowledge, either by forged signatures or trickery. For example, Mrs. D. of rural Placer County, California, a Medicare beneficiary who is legally blind, attended a seminar at a senior center presented by agents selling a Private Fee-For-Service plan. She was asked to sign an attendance sheet, but at the end of the presentation she decided to stay with her current Prescription Drug Plan (PDP) coverage, and when asked, made it clear to the agent that she was not interested. Nonetheless, she later received a letter from her former PDP informing her that she was being disenrolled because she is now enrolled in the Private Fee-for-Service plan she did not want.

Prospective enrollees are told outright lies in order to get them to join, such as: "Medicare is going private," or" you will lose your Medicaid unless you sign up." Unsolicited door-to-door sales continue unabated. Agents misrepresent themselves as being from Medicare or Social Security.

Some agents take advantage of individuals with limited English proficiency by making sales when neither the agent nor the applicant can adequately communicate with one another. Mass enrollments are occurring at subsidized senior housing facilities following no or cursory sales presentations.

Private Fee-for-Service plans are being sold as products that allow enrollees to see whatever provider they want; however, we have found that many providers are simply unwilling to accept these plans, forcing individuals to stop seeing their long-term, trusted doctors. Many beneficiaries complain that they are unable to find any local providers, including clinics and hospitals, that will accept their plan. In addition, some Private Fee-for-Service enrollees face higher out-of-plan costs than they had previously paid in original Medicare, including with a supplement or other plan.

Perhaps most disturbing of all is a continuing trend of plan sponsors and agents marketing Private Fee-for-Service plans to individuals who are dually eligible for Medicare and Medicaid, although enrollment in such a plan appears to offer little if any tangible benefit to dual eligibles and often leaves them worse off.

The following example is common. Mrs. P., a dual eligible living in California's Central Valley whose primary language is Spanish, was recently widowed and had relied on her husband to take care of her health and financial dealings. She visits her physician frequently due to a heart ailment. Mrs. P. received an unsolicited visit from an agent selling a Private Fee-For-Service plan who she says pressured her into signing up for the plan. Mrs. P. found out that her doctor does not take her plan, and she has been charged out-of-pocket costs she did not previously have to pay.

Recent proposed fixes by CMS and the industry are inadequate to stem the tide of Private Fee-for-Service marketing abuses and access to care issues. Instead, both specific and broad reforms are needed, and for these I direct you to our written testimony.

In short, since money is a main motivating factor, there must be payment parity between MA and original Medicare, and commissions paid to agents must be regulated. Plans need to know that they will be held accountable for their and their agents' conduct, and States need to be allowed a greater regulatory role to achieve this.

Finally, MA and Part D plans should be standardized and simplified so that Medicare beneficiaries can make meaningful comparisons and plans can be held accountable for providing adequate benefits.

Thank you for the opportunity to testify this afternoon.

[The prepared statement of Mr. Lipschutz follows:]

Statement of David Lipschutz, California Health Advocates, Los Angeles, California

California Health Advocates (CHA) is an independent, non-profit organization dedicated to education and advocacy efforts on behalf of Medicare beneficiaries in California. Separate and apart from the State Health Insurance Program (SHIP), we do this in part by providing support, including technical assistance and training, to the network of California's Health Insurance Counseling and Advocacy Programs (HICAPs) which offer SHIP services in California. CHA also provides statewide technical training and support to social and legal services agencies and other professionals helping Californians with questions about Medicare. Our experience with Medicare is based in large part on our close work with the HICAPs and other consumer assistance programs that are on the front line assisting Medicare beneficiaries.

We certainly recognize that Medicare Advantage plans can be a suitable option for some people with Medicare. The recent dramatic rise in the availability of and enrollment in a particular type of Medicare Advantage plan, private-fee-for-service (PFFS) plans, though, has come with alarming abuses surrounding their marketing and sale as well as access to care issues for many individuals once enrolled in these plans. While we have witnessed marketing abuses concerning stand-alone Part D prescription drug plans as well as other Medicare Advantage plans, the vast majority of marketing problems we have seen stem from the sale of PFFS plans.

In January of this year, California Health Advocates and the Medicare Rights Center released a report entitled "After the Gold Rush: The Marketing of Medicare Advantage and Part D Plans—Regulatory Oversight of Insurance Companies and Agents Inadequate to Protect Medicare Beneficiaries."[1] In that report we: provided

[1] See: http://www.cahealthadvocates.org/_pdf/advocacy/2007/CHA-MRC-Brief-AfterTheGoldrush-2007-01.pdf

an overview of the current Medicare landscape; reviewed rules relating to marketing Medicare products; discussed advocates' experiences with the marketing of PFFS plans to highlight agent misconduct; discussed Medicare's oversight of Part D and Medicare Advantage plans; discussed state regulation of insurance agents; and provided recommendations for stricter oversight and accountability of plan sponsors and their agents.

In this written testimony, we revisit some of the issues highlighted in our joint report, and shed light on problems that individuals face with both abusive marketing of PFFS plans and provider access and coverage issues faced by people once they are enrolled in these plans. We also provide recommendations to: 1) address specific problems relating to PFFS plans; and 2) improve the Medicare Advantage program in general in order to better serve Medicare beneficiaries.

II. *FACTORS CONTRIBUTING to MARKETING ABUSES*

The confusing structure of PFFS plans, varying commissions paid to agents by plan sponsors, and the lack of adequate agent training all contribute to the epidemic of marketing abuses witnessed across the county. It is not our intent to malign all agents selling Medicare products; we have interacted with a number of honest, ethical, knowledgeable agents and brokers who go to great lengths to ensure that they serve their clients well. The problem of marketing abuses, though, is much deeper and more widespread than just a few "bad apples" as the industry argues. Instead, as discussed below, underlying systemic issues drive this growing problem of marketing misconduct.

PFFS Plan Structure

When choosing how to obtain coverage through Medicare, an individual has a range of variables s/he must consider, based upon any current coverage s/he might have. As consumers struggle to find the best combination of prescription drug and medical benefits for their individual needs, they must navigate a dizzying array of configurations and cost-sharing arrangements available through Original Medicare, Medicare supplemental insurance plans (Medigaps), Medicare Advantage (MA) plans, and retiree or other coverage. Among the choices within MA, of course, are private fee-for-service (PFFS) plans. PFFS plans, despite their meteoric rise in enrollment over the last couple of years, are perhaps the least understood type of MA plan due, in part, to their departure from the coordinated care model of other MA plans. At the same time, PFFS enrollments have been at the center of many of the incidents of marketing misconduct and abuse reported by Medicare counselors in California and across the country.

The main selling point for PFFS plans has been that they do not restrict enrollees to a specific network of providers. Instead, PFFS plans rely on "deemed" providers who knowingly provide services to plan members and are therefore required to accept the plan's conditions and payments.[2] Providers who refuse to provide services to plan members are non-contracted providers. Generally, plan representatives have sought to create the impression that the structure of PFFS plans is comparable to Original Medicare or Original Medicare and a Medigap because of the absence of network restrictions on providers.

In the one-on-one marketing pitch, prospective enrollees are told, "You can see any doctor you want," or "You can see any doctor that accepts Medicare" without regard to which providers will actually accept the plan's payments. The reality is quite different. Enrollees can go to any Medicare provider only if the provider is willing to accept the specific PFFS plan's fees and terms.[3] As discussed below, our experiences have shown that many PFFS enrollees have had problems finding providers who are willing to accept PFFS plans.

Commissions Paid to Agents

One of the primary forces driving inappropriate sales of certain plans, we believe, is the varying commissions that plans can pay agents selling Medicare products. The current commission structure employed by most (if not all) plans—and allowed by CMS—permits marketing agents to steer consumers to plans that generate higher commissions as well as revenues for the company, regardless of whether such products are the most suitable choice for an individual consumer. We have found

[2] PFFS can also contract with providers to form a network. Most PFFS plans, however, rely on "deemed" providers who can choose treat enrollees on a per patient, per episode basis.

[3] A provider will become a "deemed" contracted provider of a PFFS plan and treated as if s/he has a contract in effect with the plan if: the services are covered in the plan and are furnished, and, before furnishing the services, the provider was informed of an individual's enrollment in the plan and given a reasonable opportunity to obtain information about the terms and conditions of payment under the plan. See, e.g. 42 CFR § 422.216(f).

that it is not uncommon for insurance companies to pay up to five times the commission for a Medicare Advantage enrollment versus a stand alone Part D prescription drug plan (PDP) enrollment.[4]

The link between aggressive marketing and the level of profitability for both agents and insurance companies is clearly demonstrated through the marketing of private-fee-for-service (PFFS) plans. Based upon our collective experiences with cases of marketing misconduct associated with the sale of Medicare products, we believe that higher commissions paid for enrolling beneficiaries in PFFS plans in particular (and Medicare Advantage plans in general) have rewarded overly aggressive and unscrupulous behavior by agents, resulting in real harm to beneficiaries. Plans and agents that steer people towards PFFS plans may be driving up costs borne by the Medicare program since PFFS plans currently receive more in overpayments than other plans. All Medicare beneficiaries are therefore subsidizing PFFS plans, whether or not they are enrolled in one.

Agent Training

Consumer advocates have found that many agents selling PFFS plans lack adequate training and understanding of the products they are selling and are also unaware of the impact that enrolling in these products might have on prospective enrollees. This is particularly alarming because agents who convince individuals to enroll in a PFFS plan can disrupt current drug or supplemental insurance coverage and even trigger an irrevocable loss of retiree coverage. Despite much apparent effort on the part of plan sponsors to motivate their contracting sales-forces to maximize sales, plan efforts to properly train their contracting agents fall short as many agents appear to be uneducated or even misinformed about the products they are desperately trying to sell. As we have experienced in our conversations with several agents, even those who are trying to do the "right thing" sometimes find it hard to obtain adequate information about the plans, from the plans themselves.

III. *MARKETING MISCONDUCT*

The confusing structure of the PFFS plan model, the commission structures that pay agents more money to enroll beneficiaries in MA products, and the lack of adequate oversight and training of agents by plans offering PFFS products has led to a storm of marketing abuse over the last year and a half. While our agency has encountered marketing misconduct relating to the sale of other MA plan types as well as stand-alone PDPs, the vast majority of misconduct we have seen has related to the sale of PFFS plans. As reported by the National Association of Insurance Commissioners, 39 out of 41 states responding to a recent survey said they had received complaints about misrepresentations by insurance agents or companies in marketing Medicare-related products.[5] As discussed below, this marketing misconduct has ranged from outright fraudulent sales practices to misleading sales due to the general ignorance about PFFS plans among many agents.

Most egregiously, there have been reports across the country of Medicare beneficiaries being signed up for plans without their consent or knowledge.[6]

Example: Mrs. D., of rural Placer County, CA, a Medicare beneficiary who is legally blind, attended a seminar at a senior center presented by agents selling a PFFS plan. She was asked to sign an attendance sheet. At the end of the presentation, she

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[4] See, e.g., "Oklahoma Chides Insurer in Medicare Marketing Case" by Robert Pear, *New York Times*, May 15, 2007—Oklahoma Insurance Dept. found that Humana paid agents selling MA plans "five times as much as the commission for selling" a PDP; also see "What Stakeholders Should Expect from Medicare Part D in 2007," presentation by Gorman Health Group (December 2006).

[5] "Oklahoma Chides Insurer in Medicare Marketing Case" by Robert Pear, New York Times, 5/15/07

[6] See, e.g., "Oklahoma Chides Insurer in Medicare Marketing Case" by Robert Pear, New York Times, 5/15/07—"Twenty-two states reported complaints of fraudulent activity like falsifying signatures on applications"; also see "Insurance Agents Charged with Defrauding Elderly" by Kelli Hernandez, *The Valdosta Daily Times* (Valdosta, GA)/*Union-Recorder* (Milledgeville, GA) 4/12/07—profiles the arrest of two former insurance agents selling Medicare Advantage products who "are alleged to have visited nursing homes and convinced seniors to fill out paperwork under false pretenses or gained personal information through conversation and forged signatures to sign consumers up for the products without their knowledge"; also see "Medicare Plans Under Scrutiny—Complaints are Adding Up from Seniors Upset with Private Health Care Packages" by Victoria Colliver, *San Francisco Chronicle*, 1/26/07—profiles Mrs. N., a 78 year old dual eligible living in Sacramento on less than $800 a month, who was approached by an agent selling Secure Horizons PFFS plans outside her housing complex last summer asking many questions; Mrs. N. answered the agent's questions, but says she did not sign up for the plan, but later received Secure Horizons enrollment materials. As she began to rack up hundreds of dollars in bills for medical expenses, her daughter asked the company for a copy of the enrollment application, and found that her mother's signature was forged.

decided to stay with her current PDP coverage, and when asked, made it clear to the agents that she was not interested. The next day she received a verification call from the plan sponsor of the PFFS product, and Mrs. D repeated that she did not want to join this plan. Nonetheless, she later received a letter from her PDP informing her that she was being disenrolled because she is now enrolled in the PFFS plan she did not want.

Prospective PFFS enrollees are also told outright lies in order to scare them into joining plans, such as "Medicare is going private" or that they will lose their Medicare or Medicaid unless they sign up for a particular plan.

Example: Ms. L., a dual eligible living in the Sacramento area, was told by an agent selling PFFS plans that Medi-Cal (the state Medicaid program) "was going out of business" and that coverage "was now transferred to private pay plans" in an effort to convince her to join the plan.

CMS Marketing guidelines prohibit unsolicited door-to-door sales by agents selling MA and PDP products. Despite this prohibition, though, this practice continues unabated as we regularly hear about Medicare beneficiaries who receive such visits. Some agents, perhaps aware of this prohibition, will cold call an individual but not appropriately identify themselves and/or the purpose of their call, and will later show up at the person's house (and, if necessary, use the "cover" of their previous call to argue that the visit was not unsolicited). Some agents misrepresent themselves as being from Medicare, Social Security, or even the local State Health Insurance Program (SHIP). Others do not identify themselves as agents selling plans, but instead as a "Certified Medicare Advisor" or "Senior Advisor" who would like to pay a friendly visit to educate you about changes to Medicare.

Example: Ms. F., a Medicare beneficiary in rural Tehama County, CA, was called by someone saying they were "with Medicare" and that seniors "do not have to have a Medicare Supplemental insurance plan" and that "Medicare is calling 65,000 seniors in the area to tell them that they should drop their plan, and choose one without a premium." The caller then said that someone would call Ms. F. to set up an appointment to come to her home and explain everything. Ms. F. then reports that an agent selling PFFS plans subsequently showed up at her door without an appointment after the first solicitation call, however Ms. F. did not enroll in the plan. Mr. M., however, who lives nearby and who received virtually the same call, was later visited by an agent selling a PFFS plan who told him that he could go to any doctor that accepted Medicare and as a result he signed up. Mr. M. later found out that half his doctors do not accept this plan.

Some agents have been outright abusive to prospective enrollees either in an attempt to make a sale at any cost, or in response to complaints made about an agent's previous conduct.[7] In culturally and linguistically diverse states such as California, some agents take advantage of individuals with limited English proficiency by making sales when neither the agent nor the applicant can adequately communicate with one another.

Example: Ms. S., a dual eligible living in California's Central Valley whose primary language is Spanish, received an unsolicited visit at her home by an agent selling a PFFS plan but who spoke little Spanish. Ms. S. understood the agent to tell her that the PFFS plan would not affect her Medicare and Medi-Cal coverage, however if she did not sign up for the plan, Medi-Cal would take her house away from her. She enrolled in the plan but subsequently found that her doctors do not accept this plan, she has had to pay co-payments out of pocket that she previously did not have, and found that the PFFS plan does not cover all of her prescriptions that she previously had covered.

A frequent—and disturbing—practice by agents involves going to senior or disabled subsidized housing complexes or senior centers either without invitation or under false pretenses such as giving a presentation about "Medicare changes." After a minimal (or no) presentation about a particular plan, the agents enroll a large number of beneficiaries all at once, without taking the time to explain the plan and the consequences of enrollment to each individual.[8]

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[7] See, e.g., "Sales Tactics Unhealthy for Care Plans" by Victoria Colliver, *San Francisco Chronicle*, 5/16/07—profiles "strong-arm tactics used by a health care salesman" who "became verbally abusive" with a prospective plan enrollee when she was hesitant to enroll.

[8] See, e.g., "A Multitude of Medicare Plans" by Tom Kisken, *Ventura County Star*, 4/1/07—profiles a sales session at an adult day care center by an agent selling PFFS plans, leading to "about 30 area seniors [to] say they were misled by overly aggressive agents and are trying to revoke their private Medicare plans." "The agent gave a short presentation on the plan and then he and others started signing up people, asking for Medicare identification numbers and other information—They were very aggressive about going to each table and getting people to sign

Continued

In addition to outright fraudulent sales practices, many PFFS marketing misconduct cases stem from the misrepresentation of plans that appears to be the result of either an agent not understanding the product s/he is selling, and/or the applicant not understanding the way the plan works (but the agent makes the sale anyway). The sheer number of Medicare Advantage and Part D plan options, the confusing structure of PFFS plans, the commissions paid to agents for the sale of certain plans and inadequate training of agents by plan sponsors (as discussed above) lead to many individuals enrolling in plans that they did not want or do not need.

Example: Mr. S. attended a breakfast sales presentation by an agent selling PFFS products at a local coffee shop in rural Northern California. Mr. S. wanted a Medigap plan, but the agent showed him brochures for several different kinds of plans. Since the agent made a PFFS "sound like it was a Medigap," Mr. S. enrolled in the plan but later found out that his providers did not take this plan.

Many agents describe PFFS plans as allowing enrollees to see "any doctor you want"—including prospective applicants' current providers—without explaining the crucial caveat that seeing an individual provider depends upon that provider accepting the terms and conditions of a given plan. As discussed below, many enrollees find that their own doctors will not accept such plans, and many have trouble finding any local doctor, clinic, hospital or other provider willing to do so.

IV. *EXPERIENCES of PFFS ENROLLEES*

As an agency that provides technical support to California's SHIP network, it is natural for us to primarily hear about problems that arise versus successes within the Medicare program. While we do occasionally hear about a PFFS enrollee who not only fully understands the way his/her PFFS plan works and is satisfied with it, or a doctor who is willing to accept a PFFS plan, this scenario is not the norm.

Many Providers Unwilling to Accept PFFS Plans

While Medicare Advantage coordinated care plans are required to maintain an adequate provider network, PFFS plans have no such requirement. As a result, our experience with PFFS plans has shown that many enrollees have found that they are unable to see their current longtime physician or obtain services from trusted hospitals, clinics and other providers in their area as they learn that these providers are unwilling to accept the terms and conditions of their plan. Numerous PFFS enrollees report difficulty in finding any physicians who will agree to treat them. Similarly, many physicians are expressing frustration with these plans, including feeling "forced into an unacceptable choice of either abandoning established patients who sign up for [PFFS plans] or having to accept the terms of participation."[9]

While it is virtually impossible to determine how many providers in a given service area are willing to accept any PFFS plans because such plans do not rely on established networks, it has become abundantly clear that many providers are unwilling to do so. Advocates across the country report counseling Medicare beneficiaries who enrolled in PFFS plans only to find that their own doctors won't accept their plan, and that often they can find no doctors who will do so. This phenomenon is reflected in recent media reports as well.[10]

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up,' said [a] social worker—They were very pushy.' Center administrators and the seniors said they thought the agent was selling a supplemental plan that added to their Medicare benefits."

[9] See American Medical Association House of Delegates, New Mexico Delegation, "Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans" Late Resolution: 1001 (I–06), Received 10/25/06

[10] See, e.g., "Growing Pains of Private Medicare Plans" by Jane Zhang, *Wall Street Journal*, 5/8/07—"while most doctors accept patients who are in the traditional [Medicare] program, some have declined to treat patients in PFFS plans"; the article also profiles Mr. S. who signed up for a PFFS plan in Oregon but "soon discovered that his doctor wouldn't accept PFFS payments, though, and that no other internists were available in his area"; "Any, Any, Any Plan May be in Trouble" by Harry Wessel, *Orlando Sentinel*, 3/15/07—"Many doctors and hospitals do not accept the Any, Any, Any plan"; "Medicare Headache: Health Care Providers Refuse to Accept Advantage" by Naseem Sowti, *Star-Banner* (Ocala, Fla.), 3/29/07—the article profiles Mr. B., who enrolled in a PFFS plan and "is yet to find a provider here who accepts the plan." The article notes that "many providers are now refusing to accept Medicare Advantage plans"; "Medicare Advantage Often Useless" by Karen Garloch, *Charlotte Observer* (NC), 2/25/07—article states "Some health insurance companies are misleading seniors into buying Medicare Advantage plans that are not accepted by many North Carolina doctors and hospitals, state insurance officials warned Thursday"; "Promises, Promises—Better check the fine print on that newfangled Medicare plan" by Michelle Andrews, *U.S. News & World Report*, 2/19/07 "Although the lack of networks makes the PFFS plans seem similar to original Medicare, many doctors and hospitals are wary of these plans and refuse to treat patients who sign up for them"; "Medicare Plans Under Scrutiny—Complaints are Adding Up from Seniors Upset with Private Health Care Packages" by Victoria Colliver, *San Francisco Chronicle*, 1/26/07—the article profiles a 74-year

Access to Benefits and Out of Pocket Costs

In addition to problems finding providers who are willing to treat them, some PFFS enrollees face higher out of pocket costs for services in PFFS plans or find that services that were previously available to them are not covered by their new plan. Some Medicare Advantage plans in general, and PFFS plans in particular, charge greater out of pocket expenses for certain services than the Original Medicare program, such as in-patient hospital stays, skilled nursing facility visits, cost-sharing for drugs covered under Part B, and durable medical equipment. Rarely are these caveats explained to prospective enrollees.

Example: Mr. and Mrs. H. who live in Visalia, CA, signed up for a PFFS plan after being promised by an agent that this plan "would not replace their coverage under the regular Medicare plan; it would just make it better", "all doctors would take" their plan, and that "they'd pay less under the new plan." The H.'s found that their doctor would not accept the plan, and that Mrs. H.'s $1,600 injection she needs every two weeks for her congestive heart failure was not covered (as it was under her previous plan). [11]

Undoing the Damage

Many victims of marketing abuse as well as PFFS enrollees who encounter trouble accessing services in their plans do not know where to turn. Plan sponsors—who are charged with policing the activity of their agents—often prove less than helpful when beneficiaries complain to them about marketing abuse. When new PFFS enrollees complain to their plan that they cannot find any providers willing to accept the plan, beneficiaries are commonly told that the plan will simply send an "information packet" to their physician, in an attempt to persuade the doctor to accept the plan.

Most Medicare beneficiaries are restricted in their ability to switch, change, or disenroll from MA and Part D plans to certain times of the year. If a PFFS enrollee wants to get out of a plan that is not right for them outside of an applicable enrollment period, they must first be aware of their right to do so, and then be able to demonstrate to CMS that marketing misconduct has occurred in order to be entitled to a special enrollment period (SEP) to disenroll from the plan. Many Medicare beneficiaries are unaware of both their rights and their ability to get help from SHIP programs and other types of assistance.

Working with CMS to process these SEPs and retroactive disenrollments can be problematic as there are no standard timelines for CMS to render decisions, follow up is inconsistent, and often decision-making about whether to grant such requests is passed back to the plans themselves. Advocates report very mixed results when trying to use CMS processes to resolve enrollment and disenrollment disputes, with timeliness and level of feedback often dependent upon which CMS personnel ends up with a particular case. Sometimes disenrollment due to marketing misconduct—or other reasons—can take many weeks (or months), and, in some instances in which beneficiaries are retroactively disenrolled from a Medicare Advantage plan with Part D prescription drug coverage, can leave a beneficiary with no Part D coverage at all.

V. *DUAL ELIGIBLES and PFFS PLANS*

We continue to see a disturbing trend of plan sponsors and their contracting agents marketing PFFS plans to individuals who are dually eligible for Medicare and Medicaid, although enrollment in a PFFS plan appears to offer little, if any, tangible benefit to dual eligibles. Dual eligibles in Original Medicare are already entitled to zero cost-sharing and benefits ancillary to Medicare. Any potential added benefits a dual eligible might receive through enrolling in a Medicare Advantage coordinated care plan are diminished by PFFS plan enrollments. Enrollment in a PFFS plan can leave, and, in many cases, has left, dual eligibles worse off by creating access to care issues, including loss of providers, and greater out of pocket expenses. Despite repeated requests, neither CMS nor plan sponsors are able to explain how the benefits offered to duals are better or more comprehensive than what duals already receive under Original Medicare and Medicaid (beyond statements such as they will receive "rich, incremental benefits" beyond Medicaid's).[12]

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old Oakland man who signed up for a WellCare PFFS plan that was supposed to provide free medication, but found that his pharmacy and doctor refused to accept it.

[11] Note: the H.'s are profiled in "Promises, Promises—Better check the fine print on that newfangled Medicare plan" by Michelle Andrews, *U.S. News & World Report*, 2/19/07.

[12] Note: our own analysis of the benefits of one PFFS plan being marketed towards duals in California—WellCare's Duet plan—has revealed that a dual eligible is only entitled to the addi-

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Example: Mrs. P., a dual eligible living in California's Central Valley whose primary language is Spanish, was recently widowed and had relied on her husband to take care of her health and financial dealings. She visits her physician 3–4 times a month due to a heart ailment. Mrs. P. received an unsolicited visit from an agent selling a PFFS plan who she says pressured her into signing up for the plan. Mrs. P. found out that her doctor does not take her plan, and she has been charged co-payments that she did not previously have to pay.

There is evidence that even some sponsors of PFFS plans realize that such plans are not the best option for dual eligibles. In a February 2007 memo to agents selling their product, Coventry/Advantra states: "Coventry Health Care believes that our Private Fee for Service Advantra Freedom products may not be the best health care coverage solution for Medicare beneficiaries who have both Medicare and Medicaid coverage (dual eligible)." The memo goes on to state several reasons for this conclusion, including: "[o]ur Advantra Freedom products will in many cases increase their financial exposure for covered services in the form of increased co-pays or coinsurance"; "[c]oordination of benefits with most states is often arduous and in some cases, state Medicaid departments prohibit coordination of benefits with Medicare Advantage plans." [13]

Other sponsors offering PFFS plans, however, have ignored this reality and continue to target this vulnerable population. Dual eligibles are being signed up for plans that their doctors will not accept and do not cover the drugs that they take. They are facing large bills that they should not have and cannot afford, and do not understand why they cannot get the medical services to which they previously had access. Duals have been enrolled without their knowledge into new plans, and some duals have been enrolled into many plans, which has confused their coverage and billing, their doctors and the plans themselves.

VI. *RECOMMENDATIONS*

The problems concerning PFFS plans relate not only to their sale, but to their structure, requiring both broad and specific changes. In our joint report with the Medicare Rights Center entitled "After the Gold Rush" we made several recommendations about the marketing of PFFS plans, including ensuring that enrollees had adequate access to providers in their area.[14] CMS has recently offered some proposals to address marketing abuses, but we believe that these measures do not go far enough to fix the entire range of problems generated by PFFS plans specifically and Medicare Advantage plans generally.

Specific Recommendations re: PFFS Plans

We would like to acknowledge that CMS has recently identified the need to improve beneficiary protections with respect to the marketing of Medicare products, as evidenced in their proposed enhanced oversight measures outlined in the Final 2008 Call Letter to Medicare Advantage and Part D Plans.[15] CMS does not, however, take immediate, decisive action that would send a clear message to plan sponsors. The Call Letter states that CMS is "considering several plan oversight features" including: required disclaimer language in all marketing and enrollment as well as sales presentations; requiring plans to provide documented training of marketing agents and brokers; using a contractor to conduct "secret shopper" tests on sales and outreach activities; and requiring plans to perform "outbound verification calls" to all new applicants to verify that they understand the plan features and do in fact want to enroll. We strongly encourage CMS to implement and strengthen their proposals under consideration, as well as mandate new requirements as follows:

- Verification calls—must be scripted by CMS and performed by an entity independent of the plan; we continue to hear from individuals who received such calls (from companies that have already been required to do so through CMS corrective plans) yet still are confused about what they were told and who still wish to disenroll.

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tional nominal benefit of a pair of eyeglasses every year, whereas the state Medicaid agency provides eyeglasses every two years.

[13] See Coventry/Advantra Freedom memoranda to "Advantra Freedom Agents" entitled "Private Fee For Service Dual Eligible Enrollment" (http://www.advantrafreedom.com/content/plan/91/DPDualEligibleGuidance.pdf)

[14] See: http://www.cahealthadvocates.org/_pdf/advocacy/2007/CHA-MRC-Brief-AfterTheGoldrush -2007-01.pdf

[15] The Final Call Letter is available at: http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf

- Secret shopper programs, while helpful, appear to be reliant upon information that plans and agents provide regarding scheduled sales presentations. Such efforts will not effectively prevent prohibited door-to-door visits or monitor unscheduled, unsolicited sales at residences/facilities that often result in mass, one-time plan enrollments. In order to curb this practice, we call for prohibitions against marketing in these facilities, particularly in facilities with large numbers of low income, vulnerable dual eligibles.
- PFFS plans should be required to verify that a prospective enrollee's doctor(s) will accept the plan prior to processing enrollment.
- PFFS plans should not be sold in areas in which a threshold number of providers do not accept the plan. Therefore plan sponsors should, prior to selling plans in a given area, poll major providers (e.g. hospitals, clinics, physician groups) in that area to ensure that enrollees will have sufficient access to providers.Mandatory agent training—CMS should require all MA plans (and PFFS sponsor in particular) to provide a standard curriculum with accompanying testing by an outside 3rd party. Minimum training should include: an overview of Medicare and all types of products (MA, PDP, Medigap); and how Medicare interacts with other coverage such as Medicaid, retiree coverage, VA, etc. In addition, agents should be required to provide information to each prospective enrollee about how to reach their local SHIP program.
- CMS must standardize and streamline the process through which plan enrollment and disenrollment disputes are handled, including SEPs and retroactive disenrollment requests. Absent a meaningful, standardized appeals process designed for these issues, resolution of beneficiary problems will remain inconsistent and incomplete.
- Public disclosure of corrective actions—when advocates file complaints with Medicare about plan conduct, the results of these complaints, if any, are rarely made available. In an effort to encourage Medicare beneficiaries to report bad plan conduct—and to deter plans from engaging in such conduct—CMS should make sanctions and other corrective plans/efforts it imposes on plans publicly available and easily accessible, including through their website.
- Dual eligibles and PFFS plans—as discussed above, enrollment in a PFFS plan appears to offer little, if any, tangible benefit to dual eligibles, and in many cases leaves them worse off regarding access to care and out of pocket expenses. Despite repeated requests, neither CMS nor plan sponsors have been able to explain how the benefits offered to duals are better or more comprehensive than what they already receive through Original Medicare and Medicaid. Dual eligibles and those that counsel them should have access to direct comparisons between benefits offered by PFFS plans and those available through state Medicaid programs. In addition, clear information about how and whether state Medicaid programs pay cost-sharing for duals enrolled in these plans, what liability duals have for plan co-payments when a provider is not participating in the state's Medicaid program, and how both enrollees and providers are educated about this process, needs to be made available. Unless plans can prove they provide meaningfully better and more comprehensive benefits than those currently available through state Medicaid programs, we call for a ban on the sale of PFFS plans to dual eligibles.
- Special exemptions that allow PFFS plans to operate without the basic consumer protections that currently apply to other MA plans should be removed. The most egregious of these exemptions forbids CMS from reviewing PFFS benefit packages to ensure they fairly and equitably reflect the payment they receive from Medicare.

Broad Medicare Advantage Recommendations

Many Medicare experts—from academics to advocates—question both the wisdom of the PFFS plan model and relative expenditures between the Original Medicare program and Medicare Advantage plans generally and PFFS plans specifically. As a general principle, we believe that PFFS plans should play by the same rules as all other MA plans, and should be held to the same standards; the value of their benefit package should be commensurate with what they are paid. We are convinced that much of the marketing abuses flow from money—both paid to PFFS plan sponsors by Medicare, and to agents selling these plans through commissions. Unless payment to Medicare Advantage is on par with the Original Medicare program, and commissions are more uniform, financial incentives will continue to contribute to abusive sales of these products. In addition, there are several ways in which the Medicare Advantage program in general can be improved to better serve enrollees. We offer the following broad recommendations:

- Product standards and simplification—we believe that MA and Part D plans should be standardized and simplified so that Medicare beneficiaries can make meaningful comparisons, and plans can be held accountable for providing adequate benefits. Among other things, standardization should include limits on out-of-pocket spending, and a requirement that MA plans charge no more cost-sharing for services than what is charged under Original Medicare (e.g. inpatient and SNF stays, home health services, Part B drugs, DME, etc.)
- Apply the standardization and simplification requirements of the NAIC Medigap Model Act and Regulation to all Medicare Advantage and Part D plans, including:
  - Loss ratio standards to limit administrative costs and ensure adequate funds for medical care
  - Guaranteed renewability requirements to ensure stability of benefits
  - Suitability requirements to ensure the right set of benefits is sold to meet individuals' need
  - Required disclosures that include notice of availability of SHIP counseling
  - 30 day "free look" to allow time to examine plan documents and seek counseling
  - Replacement disclosure and standards to ensure that people understand differences between current benefits and replacement coverage
- State enforcement of marketing standards—all plans supposedly have protections in place, but marketing abuses continue; in addition, CMS has so far been lax in its oversight role of plans. Unless there is enforcement by state regulators that penalizes plans—instead of just agents—abuses will continue. States should be empowered to enforce marketing guidelines along the same lines as the Medigap Model.
- Commission standards—the current commission structure employed by plan sponsors creates an incentive to sell certain MA plans over PDP plans, regardless of whether it is the best option for an individual. Medicare should require plans to adopt the concept of limiting replacement commissions to discourage inappropriate replacements (in other words, an agent should not get the same commission for selling a person a second PDP or MA plan versus the first time they enroll in one). Further, because enrollment in PFFS plans raise costs to Medicare, commission structures that create incentives for sale of PFFS plans over subsidized Medigap plans may bear scrutiny under anti-kickback and fraud and abuse statutes.
- Eliminate the lock-in provision—instead of restricting most beneficiaries to making plan choices to certain times of the year, we believe that all Medicare beneficiaries should be allowed to change plans on a monthly basis. Coupled with the recommendations we make above re: suitability standards and replacement commissions, this would allow enrollees to undo bad choices more easily.

VII. *CONCLUSION*

In order to ensure that Medicare beneficiaries are able to access timely and quality health care as well as make informed decisions about how they wish to access their benefits through the Medicare program, Congress and CMS must: 1) act to protect Medicare beneficiaries from abusive practices relating to the sale of PFFS plans; and 2) assess the overall suitability of the PFFS plan model in relation to enrollees' ability to access benefits.

Thank you for the opportunity to provide these comments.

and a companion memo entitled "Institutionalized Member Enrollments." (http://www.advantrafreedom.com/content/plan/91/FCInstitutionalMembers.pdf)

Chairman STARK. Thank you very much.

Mr. Slabach, would you like to tell us what happens in the rural part of our country.

STATEMENT OF BROCK A. SLABACH, ADMINISTRATOR, FIELD MEMORIAL COMMUNITY HOSPITAL, CENTREVILLE, MISSISSIPPI, ON BEHALF OF THE NATIONAL RURAL HEALTH ASSOCIATION

Mr. SLABACH. I would, please. Thank you. Mr. Chairman, Ranking Member Camp, and distinguished Members of this Com-

mittee, thank you for the opportunity to testify on the impact of MA Private Fee-for-Service plans in rural America.

My name is Brock Slabach, and I serve as a board member for the National Rural Health Association (NRHA), and the privilege of being the administrator of a Critical Access Hospital in rural Mississippi, which also operates three rural health clinics.

Mr. Chairman, rural Medicare beneficiaries deserve a Medicare plan that is sensitive to their needs and provides security to the fragile rural health care safety net. The NRHA is a national nonprofit membership organization whose mission is to improve the health of rural Americans by providing leadership on rural health issues. NRHA has a significant concern over the implementation of Private Fee-for-Service plans in rural America.

In 2003, Congress fundamentally changed Medicare in ways not yet fully understood by both the public and providers. What we do now know is that MA plans, as they gain more rural market share, the consequences to rural health can be possibly quite negative.

In 1997, the Balanced Budget Act created the Critical Access Hospital, which guaranteed cost-based reimbursement. This essential provision ensures access to care for those 27 percent of Medicare beneficiaries that reside in rural America.

These Private Fee-For-Service plans have the potential of completely undoing the reimbursement structure that Congress created. Rural America cannot wait to see what MA does or doesn't do. Potential problems need to be resolved before the MA program becomes entrenched. MA must be implemented in a manner that is sensitive to the needs of rural communities. If not, the negative impact on the rural health care infrastructure could take a generation to rebuild. Seniors should not be required to lose access to local health care services to gain the promise of increased benefits.

Can MA Private Fee-for-Service plans impede access in rural communities? I believe that the answer is, quite simply, yes. These include several items:

Unfair compensation to providers: Under such plans, providers often receive far lower reimbursement than under Medicare, and the system is plagued with intrusive precertification requirements and denial of claims. Each places the provider at risk.

Confusing for the beneficiaries: This includes questionable marketing practices, as has already been discussed, seniors that don't fully understand the plan designs around Part D coverage, and there are many examples in my own community which I can detail later if you would like.

Potentially place the health care safety net at risk in rural areas, and then the deficiency of coverage: While choices certainly for our seniors can be considered a good thing, it is when the beneficiary actually needs health care services is when they discover the gaps in their coverage. Often we in our facilities are the ones to communicate to the patient what it is that they have enrolled in at the time of service.

While Congress debates this issue, it is important to remember that MA is still unfolding. With its full effect yet to be seen, and currently only 5.6 percent of rural beneficiaries are enrolled in MA plans, yet this causes concern as it is growing.

In the past year enrollment has doubled, as has already been indicated, and 44 percent of Medicare beneficiaries are enrolled in MA plans. Therefore, Mr. Chairman, it is imperative that rural beneficiaries have the following assurances: appropriate access to local care; benefit equivalence to those offered in urban communities; and payment rates high enough to sustain a viable rural health care system.

To that end, the NRHA makes the following recommendations to Congress:

1) Ensure that rural providers receive equitable reimbursements in amounts no less than what they would have been paid by traditional Medicare. Legislation has been introduced to assure this.

2) Payments to MA plans should not rely on payment mechanisms that reward regions with high utilizations at the expense of regions with lower utilization.

3) Require CMS to engage with rural health experts regarding how to determine and enforce rural community access standards and mandate that MedPAC, which advises Congress on Medicare, have proportional rural representation.

Then, finally, provide our own Federal Office of Rural Health Policy in HHS expanded authority to provide technical assistance and outreach on ways rural providers can collaborate in review of MA contracts.

Mr. Chairman, Medicare must continue to improve, but the fragility of both our seniors and the rural health infrastructure demands something more than the MA plans offer today.

We can and must do better for our seniors. Thank you for this opportunity to testify to this Committee today.

[The prepared statement of Mr. Slabach follows:]

Statement of Brock Slabach, Administrator, Field Memorial Community Hospital, Centereville, Mississippi, on behalf of the National Rural Health Association

On behalf of the National Rural Health Association (NRHA) and as a hospital administrator of a critical access hospital in Centreville, Mississippi, thank you for this opportunity to testify before the committee on the impact, or lack thereof, of Medicare Advantage (MA) plans, especially Private Fee-for-Service (PFFS) Plans, in rural America. The NRHA is a national, non-profit membership organization whose mission is to improve the health of rural Americans. NRHA provides leadership on rural health issues through advocacy, communications, education and research.

Rural beneficiaries enrolled in PFFS disproportionately outnumber their urban counterparts and often require greater chronic care. Rural Medicare beneficiaries deserve a Medicare plan that is sensitive to their needs and provides security to the fragile rural health care safety net. This testimony focuses on the NRHA's concerns for MA expansion in rural areas across the nation and the NRHA's recommendations to Congress on how to best provide for the needs of our senior populations in rural America. Our primary concern is payment equity and access to care in the Medicare system, especially in traditional Fee-for-Service and PFFS, where rural beneficiaries are most likely to enroll.

Medicare Advantage for Rural America?

INTRODUCTION

The enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003 fundamentally changes Medicare in ways not yet fully understood by either the public or providers. Medicare Advantage (MA) is intended to fulfill the goals of (1) substantially increasing the number of Medicare beneficiaries enrolled in private health insurance, based on the premise believed by many policy makers that competition among these private health plans and between these plans and the traditional fee-for-service Medicare program will reduce federal spending; and (2) creating opportunities for beneficiaries to enroll in richer benefit packages than

available through traditional Medicare (sometimes with tradeoffs regarding choice of providers and drug formularies, and oftentimes at a higher cost than the cost of care under traditional Medicare fee-for-service). Policy makers may also believe, at least implicitly, that private health plans can be held accountable for healthy outcomes for enrollees, as measured against benchmarks established by the National Committee for Quality Assurance.

The focus of my testimony is to address MA implementation in regard to PFFS issues relevant to rural communities. It assumes that the federal policy of "privatizing" Medicare to create a competitive structure to cut costs will continue. It is left to others to argue the probability of MA taking permanent root in rural America, in a way its predecessor, Medicare+Choice, did not. This is a serious question as currently only 5.6 percent of rural Medicare beneficiaries have joined a MA plan. However, those that join MA plans in rural America are five times more likely to join PFFS than their urban counterparts. What we know from this is that if MA plans gain rural market share, the potential consequences to rural health from PFFS is significant, and potentially quite negative.

Rural America cannot wait to see what MA does or doesn't do. Potential problems need to be identified and resolved before the MA program becomes entrenched and less readily adjusted. MA must be implemented in a manner that is sensitive to the needs of rural communities. If not, the negative impact on the rural health care infrastructure could take a generation to rebuild. Medicare beneficiaries should not be required to lose access to local services to obtain the promise of increased benefits.

WHAT IS THE POTENTIAL DOWNSIDE OF MEDICARE ADVANTAGE IN RURAL COMMUNITIES?

With MA, beneficiaries' access to benefits and to local providers is determined by private sector health plan contracts with beneficiaries and with providers and only indirectly by Medicare. The spread of MA fundamentally changes how beneficiaries, providers, private health insurance plans, and the Centers for Medicare and Medicaid Services (CMS) will relate to and work with each other. As these relationships change, there is a real and significant risk to beneficiaries' access to local care and to the ability of rural hospitals and doctors to provide local services. Medicare must continue to improve, but the fragility of our seniors and the rural health infrastructure demand something more than the haphazard approach observed to date.

Regional Preferred Provider Organizations (RPPOs) are MA private health insurance plans that must provide uniform benefit packages and premiums to all beneficiaries in a state or combination of states—rural and urban areas alike. RPPO plans are required to gain a certain density of network providers within their geographic area or provide out-of-network services to beneficiaries at in-network cost-sharing levels. They differ from other MA health plans in this respect since all other types of MA plans are able to determine their own service area. As an incentive for the growth of RPPOs, Congress created a "stabilization fund" that CMS can draw from to make "extra" payments to the RPPOs to incent their development. Congress was explicit in its intent to encourage private plans' growth in rural areas. In addition, many of these same insurers have the very real advantage of already contracting with beneficiaries for their Part D pharmacy coverage—the perfect platform from which to sell RPPO products. However, as of November 2006, there is very little enrollment in regional plans and the requirement that new PPOs must be regional expires on January 1, 2008. Therefore, enrollment in these regional plans may remain very low. Furthermore, the Tax Relief and Health Care Act reduced funding to the "stabilization fund" to $3.5 billion, and delayed availability until 2012.

Private Fee-for-Service (PFFS), unlike other MA plans, are similar to traditional Medicare in that they do not include a care management component. Presently, PFFS plans are available in 96 percent of rural counties, and are the most prevalent type of private Medicare plan in rural areas. There are two kinds of PFFS plans that are quite different. The first, the "non-network" model, allows PFFS plans to operate without a contracted network of providers, but these plans must pay all providers at rates that are "comparable to traditional Medicare rates." For providers whose payments are "cost-based" under traditional Medicare, this provision appears to be being interpreted as the provider's interim payment rate (without the usual year-end cost settlement). The second model, still rare, is a PFFS plan with a contracted network. Contracted or deemed providers in these plans may be paid at rates lower than traditional Medicare, if community access standards are met.

Under both PFFS models, providers can be "deemed" (for a particular plan enrollee for a particular visit or admission) to be PFFS plan providers. This means, without knowing it, the provider may have agreed to accept the plan's terms and

conditions, including the rate of payment. Three conditions must be met for a provider to be deemed a PFFS plan provider: (1) the provider must know that the patient is a member of a PFFS plan, (2) the provider must be aware of a PFFS plan's terms and conditions, and (3) the provider must perform a covered service for the patient. As a deemed PFFS plan provider, a provider must accept, as payment in full, whatever rate that particular PFFS plan pays their other contracted providers. This is a grave concern for many rural providers as it may have the effect of reversing programs established by Congress, such as Critical Access Hospitals and Rural Health Clinics, which have provided payments that allow access to care in rural communities. In addition, as "non-network" PFFS plans gain market share, it is reasonable to assume these plans will convert to the "network" PFFS model and become aggressive in negotiating rates below traditional Medicare payment rates and below the cost of care in rural communities.

MA has the potential for significant beneficiary confusion. Choice is generally thought to be good but too much choice, too much variation among MA health plans, makes comparison shopping difficult, particularly for the elderly. The potential for confusion extends to the type of private plans and the relative merits of the type of plans in comparison to each other and to traditional Medicare, leading to a concern regarding potential abuse of the system. Testimony at field hearings by the National Advisory Committee on Rural Health and Human Services cited significant confusion by the elderly, an issue that is not unique to rural beneficiaries. Recently, the HHS Office of the Inspector General announced that the Office is evaluating whether certain health insurers are coercing beneficiaries to enroll in an MA plan that would include prescription drug benefit (MA–PD) versus a stand-alone drug benefit program.

Enforcement of Community Access Standards is absolutely critical to prevent steerage of Medicare beneficiaries and inordinate leverage by MA plans against rural providers. The MA program statutes and regulations require CMS to ensure that plan enrollees have reasonable local access to covered services. How CMS and MA plans interpret what is "reasonable" is critically important to rural beneficiaries and providers as well as to the acceptance of MA plans in rural communities. As stated in the CMS Medicare Managed Care Manual: "Plans must—ensure that services are geographically accessible and consistent with local community patterns of care." It is not known how or whether CMS is enforcing this provision with PFFS and RPPO plans. Anecdotal evidence to date indicates enforcement is lax at best.

If beneficiaries enrolled in an MA plan are not well informed about their rights to access care locally, they are less likely to exercise that right. This knowledge is particularly important for enrollees in RPPO plans, since they have the right to obtain services from certain non-network providers at in-network rates if the plan's provider network is inadequate in the beneficiaries' area. If CMS does not diligently monitor and enforce plan compliance, plans will have significantly less incentive to contract with a region's rural providers, undermining the rural health infrastructure in the effected communities. Plans could end up steering rural beneficiaries away from their local health care providers, forcing beneficiaries to leave their community for care that's available locally. This loss of volume could lead to the closure of local services and loss of access to care for all beneficiaries in the community as well as all other local residents.

MA has the potential to destabilize the existing rural safety net. Whether or not MA plans will honor existing rural add-on payments for safety net providers is not known. All MA plans, except "non-network" model PFFS plans, are permitted to negotiate payment rates with providers at levels below amounts the providers would receive under traditional fee-for-service Medicare. This is a process that seems to favor the MA plans, particularly in rural areas where providers may have little managed care contracting experience and little or no negotiating power such as in less remote areas where MA plans can threaten to steer patients to other contracted providers. In some rural areas, individual providers may be able to force fair negotiations because of isolation from other providers and therefore a position of strength vis-&-vis health plans needing to include them to meet access standards.

Under traditional Medicare, many rural providers receive special payment rates to reflect the various financial challenges of providing health care in rural areas. These payments were factored into CMS' benchmarking process that's described below. There is a concern whether the MA plans will recognize these targeted rural special payments that have been part of traditional Medicare payments to rural providers.

The promise of additional benefits to beneficiaries from MA plans is unevenly distributed. The technical specifics of the MA bidding process create inequities in the availability of plans with reduced cost sharing or additional benefits in rural areas. The benchmarks used in the bidding process are based on historical Medicare fee-

for-service payments at the county level, incorporating historical geographical variation in Medicare expenditures. In general, urban areas have higher physician-to-patient ratios, higher rates of utilization and consequently higher benchmark rates. The degree to which rural county level payment "floors" mitigate this issue is not known. Opportunities for additional savings and benefits should not be based on a system that primarily rewards areas that historically have excess utilization and provides minimal incentives to maintain reasonable utilization in those places where the amount of care provided is already close to appropriate levels, or in fact too low.

Traditional Medicare is not a safe harbor. If the past is a guide, economic incentives will incent MA plans to expand by attracting healthier, lower-cost beneficiaries from traditional Medicare (based on the experiences of Medicare HMOs in the 1980s and 1990s). This would have a negative effect on the traditional Medicare program, leaving it with a disproportionate number of sicker and older patients. Traditional Medicare would be left burdened with higher costs, increasing the political pressure to reduce traditional Medicare's benefits and provider payments. The actual impact of enrollment in MA plans will be more complex than earlier managed care efforts because of provisions of the 2003 legislations that provided for full implementation of risk adjustment, use of corridors to protect plans from unpredicted risk associated with adverse selection, and enrollment in special needs plans that are marketed specifically for chronically ill beneficiaries (the number of such plans grew in 2006 and again in 2007). Nevertheless, the possibility remains that the earlier experience of favorable risk enrollment in MA plans could be repeated.

CMS needs to walk the transparency talk. CMS's Hospital Compare web site is based on the concept that it is good to make provider performance available to the public. Similarly, detailed data describing CMS and plan performance must be publicly available. Just one example: enrollment figures for MA plans in rural communities were not made public until almost a year after MA plans began enrolling beneficiaries. How plans are managing the communication with beneficiaries around the key issue of access standards and how CMS is monitoring compliance to these standards is also unknown.

RECOMMENDATIONS of the NRHA

- The Congress should pass legislation that ensures Critical Access Hospitals and Rural Health Clinics are paid by MA organizations an amount equivalent to or no less than they would be paid by traditional Medicare. The Rural Health Services Preservation Act of 2007 (S. 630, H.R. 1563, and H.R. 2159) is an example of recommended legislation.
- CMS must engage with rural health experts regarding how best to determine and enforce rural community access standards consistent with individual communities' historic/present patterns of care. CMS must also engage with rural citizens about these standards by developing more user—friendly web sites, train more call center workers who understand the "older learner" and/or their (mature) children or friends who have questions.
- CMS must take action to ensure that beneficiaries are given the information and support to allow them to make well-informed decisions, particularly for rural beneficiaries who typically have less experience with managed care.
- CMS Regional Offices must regain their role as an access point by providers in their regions for definitive MA information and an ombudsman for dispute resolution with plans.
- CMS needs to continue providing county or equivalent specific plan enrollment data and in a timely manner (quarterly over time).
- A web site is needed for providers to verify beneficiaries' current plan enrollments.
- The approval process of MA plans and amendments needs to be transparent, including web-based access to the details of the approved applications.
- Payments to MA plans should not rely on a payment mechanism that rewards regions with high utilization at the expense of regions with lower utilization.
- Administration of PFFS plan payments to non-contracted providers needs to be improved. Situations where intermediaries artificially keep interim rates low as well as the fact that the CRNA pass-through and bad debt are not included in interim rates, need to be addressed.
- The Federal Office of Rural Health Policy should be given expanded authority to provide technical assistance and outreach on ways rural providers can collaborate in the review of MA contracts.
- Congress should increase funding for local organizations serving the elderly to provide increased technical assistance to beneficiaries enrolling in MA plans.

• State insurance commissioners' offices should be encouraged to act as state level ombudsmen for rural beneficiaries enrolled with MA plans.

CONCLUSION

Medicare Advantage is still unfolding, with its full effect yet to be seen. If the privatization of Medicare in rural America is only partially accomplished, the rural health landscape will be significantly transformed. It is imperative that (1) rural beneficiaries are ensured appropriate access to local care, (2) rural beneficiaries have access to and receive the benefits equivalent to those able to be offered by MA in urban communities, (3) payment rates are high enough to sustain a viable rural health system, and that (4) the relationship among beneficiaries, providers, plans and, CMS be well integrated.

Chairman STARK. Thank you.

Catherine Schmitt is the Vice President of Federal Programs for Blue Cross Blue Shield of Michigan. Would you care to enlighten us in any manner you are comfortable, Ms. Schmitt.

STATEMENT OF CATHERINE D. SCHMITT, VICE PRESIDENT, FEDERAL GOVERNMENT PROGRAMS, BLUE CROSS BLUE SHIELD OF MICHIGAN, DETROIT, MICHIGAN

Ms. SCHMITT. Mr. Chairman, Representative Camp, and Members of the Committee, as previously stated, my name is Catherine Schmitt and I am Vice President of Federal Programs at Blue Cross Blue Shield of Michigan. I appreciate the opportunity to testify on the Private Fee-for-Service option in the MA program.

Blue Cross Blue Shield of Michigan is a nonprofit health plan that :]serves nearly five million members, of which 440,000 are beneficiaries enrolled in government-contracted MA, Private Fee-for-Service, and Part D products in every county in Michigan. My testimony today focuses on the importance of this option in meeting the needs of employer and union retirees in the state of Michigan.

We believe that it is critical to preserve the option because it is the only MA product available today for bringing uniform integrated health benefits nationwide to the retirees of major employees and unions. This option allows employers, like the Michigan public school retirees, which includes the cafeteria workers, bus drivers, and custodians, to provide nationwide retiree health plans identical to the benefit programs they offer other group members, incorporating the same care management features through a single plan.

There are three key reasons why it is important to preserve the product. First, care coordination: There is a common misperception that these plans cannot provide any advantages with regard to improving member health. In fact, this is one of the key reasons why employers are interested in this product. Our plans offer care coordination and management for disease that commonly afflict the elderly through an integrated benefit package. For example, we provide access to 24 by 7 nurse consultants, personal health care coaches for chronic conditions, as well as complex and care management.

The second key reason is that these products provide access in rural areas. For the first time, all Medicare beneficiaries have access to private Medicare plans.

Third, Private Fee-for-Service plans offer members enhanced benefits. In addition to filling gaps with these benefits, customized care management plans can be developed for the most complex of cases.

I would also like to address some of the criticisms of Private Fee-for-Service plans, starting with the most disconcerting, unscrupulous and even fraudulent sales practices. I can only imagine the trauma to victimized beneficiaries. We strongly support the marketing guidelines that CMS has put in place for this product and their efforts to strengthen enforcement. Please note, however, that these sales problems are not an issue with employer and union accounts.

Some have questioned the care management exemption Private Fee-for-Service plans have from requirements that apply to Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Some of these exemptions continue to make sense for Private Fee-for-Service plans. However, plans should report Health Plan Employer Data and Information Set quality data. Reporting of quality data will enable Medicare beneficiaries to make informed health plan choices. Private Fee-for-Service plans should be required to establish chronic care improvement programs, with participation voluntary by the members.

Another concern identified by MedPAC is that average payments for Private Fee-for-Service plans are 119 percent more than traditional Medicare, compared to 12 percent more for all plans. Blue Cross Blue Shield of Michigan actuaries have found that payments for our employer and union Private Fee-for-Service products are not higher than the average. For groups, all retirees, regardless of county-specific reimbursement, are enrolled.

I urge you to reject further cuts in funding for this program. Congress improved payments under the Medicare Modernization Act to ensure broader access in rural areas and to stabilize the program. The $6.5 billion in cuts already enacted under the Deficit Reduction Act (P.L. 109–171) has resulted in MA rates that are rising significantly below the growth in medical costs.

If Congress cuts MA funding, the Private Fee-for-Service product is unlikely to remain a sustainable product in many areas. Members will not be able to sustain the premium increases, which is exactly what happened to Medicare+Choice. The result may well be most, if not all, of the 1.3 enrollees in this product will have a disruption in care, lose access to the enhanced benefits, and lose opportunities for care management.

What would the loss of Private Fee-for-Service mean for Michigan? It will mean that beneficiaries who do not qualify for Medicaid but cannot afford a Medigap policy will be left without supplemental coverage. It will mean that employers and unions will be forced to make hard choices about reducing benefits. It will mean the beneficiaries lose confidence in Congress, CMS, and their health plans to ensure continuity of care and help them maintain predictable coverage and premiums.

Thank you for considering my perspective on the MA Private Fee-for-Service program.

[The prepared statement of Ms. Schmitt follows:]

Statement of Catherine Schmitt, Vice President, Federal Government Programs, Blue Cross Blue Shield of Michigan, Detroit, Michigan

Mr. Chairman, Representative Camp, and members of the committee, my name is Catherine Schmitt and I am Vice President of Federal Programs at Blue Cross and Blue Shield of Michigan. I appreciate this opportunity to testify on the Private Fee-for-Service option in the Medicare Advantage program.

Blue Cross and Blue Shield of Michigan (BCBSM) is a non-profit health plan that serves nearly five million members, of which 440,000 are enrolled in government contracted Medicare programs. Nearly 70 years ago, Blue Cross Blue Shield of Michigan started with a purpose to provide people with the security of knowing they have health care when they need it. Today, that nonprofit mission is the same and we're accomplishing it in many ways, including offering access to health care coverage for everyone, regardless of circumstances as the insurer of last resort.

Blue Cross Blue Shield of Michigan is committed to offering Medicare products that meet the needs of the individual members, employers and unions that we serve. We offer a range of plans to Medicare beneficiaries in every county of the state of Michigan, including Medicare Advantage (MA) Private Fee-For-Service (PFFS) plans, Medicare Part D coverage, and supplemental coverage. The BCBSM enterprise also offers a MA HMO product in counties where an adequate network could be developed. Our Medicare Advantage plans play an important role in providing comprehensive, coordinated benefits for seniors and disabled members who might not otherwise have affordable alternatives for supplemental benefits in Michigan.

In my testimony today, I will focus primarily on the importance of the PFFS plan in meeting the needs of Medicare eligible beneficiaries who are retirees of employers and unions in the state of Michigan. We believe that it is critical to preserve the PFFS option because it is the only product available today for bringing integrated health benefits to the retirees of major employers and unions nationwide under the Medicare Advantage program.

II. Why did BCBSM offer a Private Fee-for-Service Plan?

BCBSM has traditionally served the Medicare population through Medicare supplemental plans, or Medigap. However, with the passage of the Medicare Modernization Act (MMA), which addressed inadequate payment levels in Michigan that had made Medicare+Choice plans unsustainable, we saw an opportunity to make comprehensive coverage through Medicare Advantage and Part D plans available to our customers.

We chose the private fee-for-service plan for a number of reasons. In the individual market, we needed a less costly alternative to Medigap, which had become too expensive for many of our customers. Even with a dedicated contracting team, broad based network health plans take years to develop as the health care providers will not contract initially for the Medicare allowable amounts. They want much higher payments and re-contracting would have taken considerable lead time. So, we found ourselves with many Medicare members who have been with Blue Cross and Blue Shield their whole life and we wanted to be able to continue to serve them if they were interested in enrolling in a Medicare Advantage plan.

At the same time, employers were asking for alternatives to their current arrangements which supplement Medicare but do not coordinate care or focus on health improvement. Our employer and union customers needed a solution for serving retirees all over the country and using a state-wide PPO would leave no choices for the group with retirees residing in different parts of the country like Arizona, California, Florida and New Mexico. Due to a combination of regulations that prevent PPOs and HMOs from offering coverage to retirees outside of their state and the lack of nationwide acceptance by providers to participate in networks for Medicare Advantage products, PFFS is the only option available for serving these members.

So we did our business analysis and decided that private fee-for-service would allow our employers to provide retiree health care plans identical to the benefit programs they offer active and non-Medicare eligible retirees nationwide incorporating the same care management features such as care coordination and disease management programs through a single Plan eliminating the need to stitch together multiple HMO or PPOs that would cover only a portion of their retirees nationwide.

I would like to share with you an example of our largest group account enrolled in PFFS and explain why this coverage is so valuable to them. The Michigan Public School Employees Retirement System (MPSERS) implemented a Medicare Part D Prescription Drug Plan in 2006 and a Medicare Advantage private fee-for-service plan in 2007 in order to lower health care costs and improve health care management and outcomes for their Medicare eligible retirees.

There are more than 115,000 MPSERS members in the Medicare Advantage private fee-for-service plan. Many include lower-income retired clerical staff, bus drivers, janitors and cafeteria workers. Medicare Advantage provided MPSERS with an opportunity to reduce the System's cost and integrate coordinated medical and drug management programs. This option also allows them to manage health care costs without reducing school programs for the students.

III. The Importance of Maintaining the PFFS Option

In addition to the fact that PFFS is the only option available to employers and unions on a national basis, which was the major reason that we offered this product in the group market, I would like to stress three reasons why it is important to preserve this product: opportunities for care coordination, providing rural beneficiaries with access to an MA option, and providing enhanced benefits and protection from the high out-of-pocket costs of traditional Medicare.

Care Coordination

There is a common misperception that PFFS plans cannot provide any advantages with regard to improving member health over traditional Medicare. In fact, as I mentioned, employers are turning to our PFFS product in large part because they cannot provide the same care management programs that are available to their active and non-Medicare eligible retirees.

Medicare Advantage plans meet a critical need by offering care coordination and management for diseases that commonly afflict the elderly through an integrated benefit package and this happens in our PFFS plan as well. The importance of the integrated benefits available under Medicare Advantage plans cannot be understated. With a Medicare supplemental plan, inadequate and untimely claim information does not allow for any meaningful care management. By the time information is received, it may be too long after a major event to reach out to a member, their family or providers.

Our Medicare Advantage members benefit from a variety of voluntary, patient-centered programs designed to improve their health through our BlueHealthConnection® program. BlueHealthConnection provides a spectrum of wellness, disease and symptom management, and case management opportunities for Private Fee-for-Service (PFFS) Medicare Advantage beneficiaries to take an active role in improving their health.

For example, we provide access to personal health care coaches to address a full range of health care decision needs, including management of chronic conditions, such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disorder, cancer, benign uterine conditions, and back pain. The program is focused on building self-reliance, and seeks to inform members by providing a range of information, transferring skills, building confidence, and enabling members to take action.

We also provide access to a case management program that focuses on high-cost members who are impacted by multiple co-morbidities, those who are the most difficult and costly to care for. These initiatives provide telephonic and face-to-face assessments, develop collaborative care plans with both physicians and members, and use evidence-based guidelines to measure success. Through this program, we also provide telemonitoring devices to assist health care professionals in the management of complex conditions, such as congestive heart failure.

We believe that programs offered by the Plan a member has selected such as BCBSM and is familiar with, will be far more successful than efforts by companies contracted by CMS where the beneficiary does not know or trust the party contacting them about their health care needs.

Acess for Rural Beneficiaries

Historically, the existence of private plan options in rural America has been virtually non-existent with the benefits of private plans only available to beneficiaries in urban cities. Network-based products are difficult to construct in rural areas with sparse populations and limited provider availability. In rural areas of the country, where traditional Medicare rates are very low, providers often refuse to join a plan's network unless reimbursement from the plan far exceeds what the Medicare rate would be. Unless plans can meet the network adequacy requirements of CMS at the time of application when enrollment is highly speculative, they will not be approved to participate in the MA program.

Due to the availability of PFFS plans in 2007, for the first time all Medicare beneficiaries in the country have the choice of a private Medicare plan options: a significant increase from 2004 when one-quarter of beneficiaries did not have that option. Between 2005 and 2006, enrollment in PFFS plans by rural beneficiaries accounted for 39 percent of total MA enrollment growth.

Enhanced Benefits

Our PFFS plans offer members benefits that are more generous than Medicare alone, especially in the group market. We estimate that the value of benefits offered among our plans is 21–33 percent more generous than original Medicare. This is because our employer and union accounts generally want to offer their retirees the same benefits they provide to their active workers and are willing to subsidize the group product. We also offer individual products with an actuarial value of up to 27 percent more than traditional Medicare.

Our lowest cost plan (with premiums of $0-$61 per month depending on one's area) offers a number of additional benefits not available in traditional Medicare. This plan has an annual out-of-pocket limit of $5,000 that offers the peace of mind that an unexpected illness won't result in bankruptcy. This is a benefit that is not available in traditional Medicare. Our plan has a $20 copay for doctor visits instead of the 20% coinsurance in FFS Medicare. In order to foster good preventive care, our plan has no cost-sharing for services such as home health visits, diagnostic tests, mammograms, prostate and colorectal cancer screenings and immunizations.

All of our individual plans are comprehensive MA–PD plans and groups can select either an MA–PD plan or an MA plan with the Retiree Drug Subsidy. In either case we can provide comprehensive, fully integrated programs. Additionally, members like the fact that as Medicare Advantage members they can continue to carry a single Blue card for their Medicare A and B benefits, supplemental and drug coverage.

If Congress cuts MA funding, plans will be forced to increase cost-sharing for these services, cut benefits, or increase their premiums which will most affect those seniors who are living on lower-to-modest incomes.

IV. Responding to Issues Raised regaurding the PFFS Product:

Over the past couple of weeks, a number of criticisms have been leveled against PFFS plans. Some of these concerns involve legitimate issues that industry and regulators are working to address to ensure confidence in this product. My message today is this: let's stop vilifying plans that offer the PFFS option and instead focus on correcting the abuses and improving the program. I would like to address some of these criticisms and point out a few areas where I would support improvements:

• Sales Issues: The most disconcerting concerns leveled against PFFS plans involve instances of unscrupulous and even fraudulent sales tactics involving sales of individual PFFS plans. I agree that some of the incidents were appalling and should never have happened. While the rapid growth of this relatively new product—which enrolled 1.3 million people in a very short time—is likely a contributing factor, the industry must do better. We support the marketing guidelines that CMS has put in place for this product and their efforts to strengthen enforcement of these requirements for 2008, including post-enrollment calls to verify that new individual enrollees understand the product. We continue to strengthen our agent training requirements and have a zero tolerance policy for agents that do not follow the rules. Our complaint ratio regarding agents is less than 1 for every 2,000 enrollees.

BCBSM and the Blue Cross and Blue Shield Association stand ready to work with CMS, the States and Congress to assure that the problems that occurred during the rapid growth of this option are addressed and no longer tarnish the program.

It is important to note that these sales problems simply are not an issue with employer and union accounts. Group PFFS products do not involve the use of agents or brokers for individual sales to their members. Employers and unions work with us to ensure that retirees understand these products. And, as I mentioned earlier, our group customers have a strategy of mirroring the benefits that retirees already have, which improves acceptance.

• Exemptions from Requirements that Apply to Other MA plans. Some have questioned the value of PFFS plans, given the exemptions that they have from certain requirements that apply to Medicare HMOs and PPOs. Some of the current PFFS exemptions continue to make sense, given the very different nature of PFFS plans as compared to HMO and PPO plans. However, we recommend ending two exemptions to inject more accountability and provide increased value to beneficiaries.

As I mentioned earlier in my testimony, employers are demanding that PFFS plans work to improve the health of their members and be accountable for quality. To this end, the general exemption of PFFS plans from the quality improvement provisions should be lifted with respect to the following two requirements, providing for standards appropriate to PFFS plans:

- **Reporting of Quality Data.** Currently, PFFS plans are encouraged to report HEDIS® quality measures voluntarily. CMS indicated in its 2008 call letter to Medicare Advantage organizations that it intends to use HEDIS measures in developing its MA plan comparisons starting in 2007. Including PFFS plans in

this requirement will make more meaningful performance information available to Medicare beneficiaries, and help better inform their health plan choices.

- **Chronic Care.** MA plans must establish a chronic care improvement program that monitors and identifies enrollees with multiple or severe chronic conditions. PFFS plans are exempt from these requirements. Requiring PFFS plans to establish chronic care improvement programs recognizes the importance of addressing chronic care in this population. These programs should remain voluntary on the part of members.

• Provider Acceptance. The PFFS product is unique in that it does not require use of a defined network of providers like a PPO or HMO. While this enables us to serve retirees in every area of the country, it also means that there is no guarantee that a given provider will see a patient. Our rate of provider acceptance is very high and our group customers have been more satisfied with the success we have been able to achieve for their retirees. We respond to these incidents by working to educate providers on the benefits of participation, including having the ability to receive a single payment from the health plan for all services. We have found that physician offices we contact often decide to accept our PFFS patients once they understand our products. When a provider still refuses to participate we make every effort to locate an alternative provider for the member. Despite our success, this is one area where CMS can help educate providers about these plans to ensure greater acceptance for the entire industry.

• Payment levels. Another concern leveled at PFFS plans is that their average payments are 19% more than claims costs under traditional Medicare compared to 12% more for all MA plans, according to MedPAC. BCBSM actuaries have found that the government payments for our employer and union PFFS products are not higher than MedPAC's estimate for the national average for all MA plans. This may be because when we offer a product to an employer, we do not target specific counties, but rather we enroll all of the company's retirees nationwide, regardless of where they live.

Congress should reject further cuts in funding for this program. There is tremendous variation around the nation in FFS Medicare payments to providers, which are substantially below payments to doctors and hospitals under commercial plans in most parts of the country. Congress improved payments under the Medicare Modernization Act to ensure broader access to health plan options in rural areas and to stabilize the program. Congress has already cut MA base funding by $6.5 billion in the Deficit Reduction Act (cuts that will be phased in through 2010). This is having an impact on our payments in Michigan, which are rising at a rate that is below growth in medical costs, which over time will result in increased year-to-year costs or reduced benefits for our members. This is exactly what happened in the years prior to the MMA, when Medicare+Choice became unsustainable in many counties after years of medical cost increases outstripped growth in plan payments. The result was widespread loss of coverage for Medicare beneficiaries.

If Congress adopts MedPAC's recommendations for cutting MA funding, the PFFS product is unlikely to be viable in many states. The result may well be that most, if not all, of the 1.3 million enrollees in this product will lose access to the enhanced benefits and opportunities for care coordination that come with these products. According to a study by Professors Ken Thorpe and Adam Atherly at Emory University, equalizing payments could result in 3 million people losing their MA coverage, including more than 180,000 in Michigan.

What would the loss of the PFFS option mean for Michigan? It will mean that many Medicare beneficiaries who make too much to qualify for Medicaid, but cannot afford a Medigap policy, will be left without an option for obtaining affordable supplemental coverage. It will mean the loss of care coordination and health improvement opportunities. It will mean that employers and unions struggling to maintain retiree benefits in light of new accounting rules will be forced to make hard choices about reducing retiree benefits. It will mean more confusion for beneficiaries who will lose trust in Congress, CMS and plan sponsors.

V. Conclusion

Thank you for considering my perspectives on the Medicare Advantage program. I appreciate this opportunity to testify about the importance of the private fee-for-service product. Medicare beneficiaries need stable options for supplemental benefits and PFFS plans are a major source of that coverage in many areas of the country. We urge the committee to ensure the continued viability of this product and to support adequate funding for Medicare Advantage plans.

Chairman STARK. Thank you very much.

I recognize Mr. Camp.

Mr. CAMP. Well, thank you very much, Mr. Chairman.

Ms. Schmitt, can you just describe some of the additional benefits or savings that your plan offers to the 116,000 retired school employees in Michigan?

Ms. SCHMITT. Certainly. The benefits come in both what we think of as health care benefits as well as convenience benefits. As was mentioned in the letter that you read earlier, there is a convenience and a benefit to the members in that they have one entity that they can go to to get their questions answered about their coverage. So, when they have a question, instead of first having to call Medicare and then having to call their private insurer, they can get all of the questions answered at once.

The next form is the care management programs, as I mentioned. By having members enrolled in the MA Prescription Drug product, we are able to have all of their data and identify those members that would benefit from these programs.

Then thirdly, the additional benefits that they have are the benefits that are the same as their non-Medicare-eligible retirees, which fill in the cost-sharing components of traditional Medicare as well as provide additional preventive services for the enrollees.

Mr. CAMP. Are you seeing any changes in the mix, if you will, of beneficiaries in terms of their demographics or their risk factor?

Ms. SCHMITT. Well, on the group side, the Michigan Public Schools Employee Retirement System group decided to make this a replacement product. So, it is really the exact same enrollees that we had prior to the MA product.

Mr. CAMP. Thank you. I have a question for Mr. Dilweg. Obviously, by law, CMS is limited in their involvement in MA. That is something we may need to look at, but you mentioned some of the fraudulent and misrepresentation by insurance agents, which are governed by state law. What percentage of the plans would you say in Wisconsin have you found fraudulent activity in?

Mr. DILWEG. Across the board in Wisconsin, to receive 400 complaints in a year is very high. I look back to——

Mr. CAMP. How many total plans then do you have in Wisconsin?

Mr. DILWEG. We have 92 plans.

Mr. CAMP. How many beneficiaries? If you had 400 complaints——

Mr. DILWEG. Oh, we have 833,000. We have a prescription drug waiver that is moving off at the end of the year.

Mr. CAMP. All right. So, less than a tenth of a percent of the——

Mr. DILWEG. Right. So, that is a very high complaint for us. When I hearken back to the introduction of credit scoring in property and casualty, we would see 42 complaints a year. That was a very hot issue three years ago.

Mr. CAMP. Less than a 3/100ths of a percent is considered a high complaint level?

Mr. DILWEG. No. What I am saying is a big issue like credit scoring on your homeowner's policy, that generated in 1 year 42 complaints. So, here I am dealing with 400 complaints.

Mr. CAMP, but I am looking at a pool of 800,000 people.

Mr. DILWEG. Right. Correct.

Mr. CAMP. So, it looks like it is about.03 percent. So, 3/100ths of a percent of the policies that have been written have had a complaint. Is that what I understand?

Mr. DILWEG. Correct.

Mr. CAMP. Ms. Neuman, you mention in your written testimony the hypothetical of the person in Wisconsin who had to pay higher fees, but is it true that also there would have been three plans, that that hypothetical individual would have paid less in MA than what she would have been charged in traditional Medicare? Is that accurate?

Dr. NEUMAN. There may well be. The purpose of that exercise was to illustrate some of the issues and challenged that a beneficiary could encounter. So, those three plans that we happened to pick showed how a beneficiary could end up paying more, but there are additional benefits, and depending on what an individual needs, that person could not have higher spending.

I will say after I worked on the testimony there was an article that was published in Health Affairs that did a more systematic analysis to show beneficiary spending across different types of plans. It did confirm that sicker people could end up spending more under Private Fee-for-Service than other types of plans.

Mr. CAMP, but because there are a multiplicity of plans, that beneficiary may have chosen a plan that actually had more benefits and actually cost less. I think there are three in Wisconsin that would have cost less that I know offhand. Is that a possibility?

Dr. NEUMAN. That is certainly a possibility, but I will say, Mr. Camp, it is pretty hard for beneficiaries to decipher which plan is going to put them in a better place and which is going to end up having them spend more money.

Mr. CAMP. Choices, you mean?

Dr. NEUMAN. Well, I am not saying the choices are bad. I am just saying it is pretty hard to get beyond premiums and then to assess hospital copays, home health copays, to figure out which three plans are going to have them spending more and which three plans will have them spending less.

Mr. CAMP. Yes. I understand your point. I guess I think it is important to say that yes, there could have been plans that cost more, but yes, there could have been plans that cost less. I think that would have been a little more balanced approach to the issue.

I see my time is running out, and there is a vote on, but I want to thank you all for coming, and I appreciate your testimony very much.

Thank you, Mr. Chairman. I yield back.

Chairman STARK. Thank you. I have just a couple of quick questions. One, we have a problem in that we have six votes. I will come back, and I ask your indulgence, or let us just continue with the questions, if you don't mind. I will ask the witnesses, if any of them have to leave, I will certainly understand, but if the members choose to come back and inquire.

I just wanted to inquire of Ms. Schmitt what the medical loss ratio on your Private Fee-for-Service line is.

Ms. SCHMITT. Our plans are very new, and so I can't really give you fully incurred benefits or costs at this point in time. The em-

ployer group we only brought up the first of this year, and certainly it takes a while for the claims to come through the system.

Chairman STARK. Yes. So, you haven't been in the Private Fee-for-Service business very long?

Ms. SCHMITT. We introduced the individual product late in 2005. Then we continued to—the plan grew throughout 2006, and that is where the teachers decided to enroll for the first of this year.

Chairman STARK. Do you know what your average bid was in relation to fee-for-service Medicare?

Ms. SCHMITT. As a percent?

Chairman STARK. Of fee-for-service, what your average bid—you submit a bid as a percentage of fee-for-service. Do you know what that was?

Ms. SCHMITT. Let me check that. I would like to be sure that I give you the exact, correct information because we do have multiple plans, and I want to——

Chairman STARK. How close can you come?

Ms. SCHMITT. Well, I will get that submitted to you first thing in the morning.

Chairman STARK. I am going to ask Trish—if she was still on my staff, I would ask her the same question because she can do this kind of math with her shoes and socks on, but what I am hearing about the Michigan plan is that Blue Cross of Michigan has figured out that if Private Fee-for-Service overpays them, that they can cost-shift, use this overpayment—which I call cost-shifting—to Medicare, so that basically Medicare is chipping in to pay the Medigap, if you will, for as many public employees or retired public employees as Blue Cross covers.

Now, I would guess that in California, in our California Public Employees' Retirement System, we probably have four or five million people. What a good idea. If we put them all in MA, then we bill in at about 120 percent of fee-for-service. That 20 percent would save the California taxpayers a lot of money.

Could you comment on the equity of that approach?

Ms. SCHMITT. I certainly whether or not comment on your math because I am sure it is perfect. I think the broader issue that you may be raising, Mr. Stark, is that because of the current payment system, that payments to Private Fee-for-Service plans, including payments to plans that are serving retirees, do end up using higher government payments in order to help subsidize coverage for people in retiree health systems. Employers who are under a lot of pressure may find it appealing because it will help them save some money.

Chairman STARK. Costs the rest of us taxpayers——

Ms. SCHMITT. I am. The other equity issue that you raised, I am sorry, was that—and as I said in my testimony, and probably with more power, the actuary has said these higher payments to plans are paid for by beneficiaries. In general, I think the Office of the Actuary has said that all beneficiaries who pay premiums pay an additional $2 per month, and taxpayers pay more through general revenues in order to stay in the current payment system.

Ms. SCHMITT. Could I comment?

Chairman STARK. Do you want to respond to that? Sure.

Ms. SCHMITT. Yes. I would like to make a comment. Our retention on these products is 6.4 percent. Out of that, 1.9 percent is considered to be the risk factor, both insurance risk as well as operational risk. So, that lives a balance of 4.5 percent for administrative costs, of which 1 percent is estimated to be the cost for the care management programs.

Chairman STARK. I have no question that it is financially helpful for the state of Michigan. Don't misunderstand me for a moment. I would much rather help the state of Michigan than some for-profit operator, but nonetheless, by overpaying—in other words, you could go in and provide Medicare fee-for-service, and go out into the market and by Medigap policies, and accomplish the same benefit coverage.

What you are doing, unless I misunderstand, is collecting an overpayment—and I don't say that pejoratively, but a higher than the fee-for-service—from Medicare, and that overpayment, in effect, is putting you into the supplemental insurance business and paying your costs for the supplements.

If we were to do that for everybody, if we had the money, I suppose that would be nice to do, but the fact is that when we just have a small group of people collecting this what amounts to some $60 billion over 5 years, then we are taking that—we are cost-shifting.

The question is, is that fair? What do we get back for it? I say I suspect we get a better value out of the state of Michigan than we do out of some high binder who has just got a laptop and two or three employees and is peddling this in rural areas.

Basically, unless I am wrong, Blue Cross is getting much more than the fee-for-service cost, and with that extra money, or some of it, providing what amounts to supplemental benefits. Without pegging the percentages, isn't that what is happening?

Ms. SCHMITT. Well, I do believe, as you are stating, that all of the private plans, or the vast majority, are providing some form of supplemental benefits.

Chairman STARK. Oh, no question.

Ms. SCHMITT. Yes. The other thing, though, that I would like to just mention is the fact that we have people who are moving from active coverage or non-Medicare retiree coverage, and they have had coordinated care. They have been accustomed to this. If there is ever an opportunity to move them into similar plans before they move to traditional Medicare, where there is no coordinated care, it is going to be very difficult to do it later and that opportunity is going to be lost.

Chairman STARK. I hear what you are saying. I am just suggesting to you that if we did this across the country for every retiree plan automatically, we would break Medicare in a couple of years. We just wouldn't have the money to afford it. Therein lies the problem. If the good news of what happens to the retirees under the Michigan plan and the savings that it may have even for private employers, not to mention the school districts and others who would otherwise have to pony up for this retirement, we couldn't afford it.

So, the question is, if we can't afford it for everybody, how do we limit it? That is therein—I am not trying to pick on Michigan. You

are to be commended for creative financing, but as I interpret what your plan is doing, that is what I see. I don't know how we can sustain that financially.

Mr. Doggett, would you like to inquire?

Mr. DOGGETT. Surely. Mr. Slabach, I was concerned by your testimony because I represent a number of rural communities and I know how stretched these small hospitals are to just try to stay in operation and provide services so people won't have to travel long distances to get their care.

If I understand the thrust of your testimony, and I believe you are talking about more than your own experience but what you are hearing from hospitals across the country, the same Medicare advantage plans that cost the taxpayer $120 per person more than traditional Medicare, they aren't satisfied with that margin. They are squeezing, especially the smaller rural hospitals, on what they pay, and they don't want to pay as much as traditional Medicare pays the rural hospital. Is that correct?

Mr. SLABACH. That is essentially correct. I think that what occurs in our experience, and it is replicated around the country, because we don't have a prospective contract with these countries, we are left to the retrospective evaluation of the insurance company to decide what they will pay us.

In one case—I have several cases—it has taken four to 6 months to receive payment on the services rendered. Then after we received payment on those services, the payments were inaccurate. When we had to go with the appeals processes with these companies to try to get the money that we think we were owed.

The other interesting fact is that we have a number of patients that require precertification in order to receive hospital care. Since we didn't know at the time of their admission, and the patient didn't know they were even in the plan, we assumed because they gave us their traditional Medicare care that they were traditional Medicare.

The fact-checker, the passport services, didn't tell us they were in another plan. We missed the precertification deadline. So, we could be out several thousand dollars' worth of care.

Mr. DOGGETT. Well, it is not only the amount that you get, but you have the same kind of delays from these plans that many of our community pharmacists are complaining about.

Mr. SLABACH. It is precisely that.

Mr. DOGGETT. Thank you. Since our time is short, Mr. Lipschutz and Mr. Dilweg, I was very concerned about your testimony as well. What is the general attitude of the people you deal with at the Center for Medicare about the kind of abuses that our seniors are experiencing that you have found in your work?

Mr. LIPSCHUTZ. Well, the response from CMS has, frankly, been mixed. Efforts to try to solve problems once they are identified have also been met with mixed results. One of the most frustrating things from the beneficiary and beneficiary advocacy standpoint is trying to find out the results of complaints and the results of inquiries that are made about certain issues.

Mr. DOGGETT. I have had the same experiences. Members of this Committee have written CMS. They take forever to provide a nonresponse. You have had some of those kind of same experiences

when you are inquiring about the needs of a particular senior who appears to have been abused by some insurance salesman. Right?

Mr. LIPSCHUTZ. Yes. Sometimes things are resolved quickly. Oftentimes things take much longer than they should.

Mr. DOGGETT. Mr. Dilweg, have you had a similar experience?

Mr. DILWEG. We have had a similar experience. We are obviously forced, if it is not agent-related, to simply hand it off to CMS. Then we have recently signed an Memorandum of Understanding (MOU) to share information, confidential information, on what may actually happen.

I just want to emphasize that with any other health insurer in my state, I would see these abuses and be going into the insurer, auditing their marketing practices, auditing their agent relationships. This is preventive approaches that I take with a health insurer. It is not simply punishing the agent. That is very reactive.

Mr. DOGGETT. Your comment goes to another concern that I have. This bill, this law, of course, is the product of a crowd up here that talked states' rights and then eliminated them regularly. One of the rights preempted here was the right of the state to enforce any regulations in this area. Is the preemption a problem for you in your work?

Mr. DILWEG. It is very frustrating because it ties our hands. I point to the Medigap model because it is a very good working model between CMS and the states. I think all states have adopted it, but initially some states just allowed CMS to continue regulating. So, it is a——

Mr. DOGGETT. Or nonregulating, as the case may be.

Mr. DILWEG. Correct.

Mr. DOGGETT [Presiding]. I believe that our time for votes is about up, and so I will formally recess subject to the call of the Chair. We will recess subject to the call of the Chair. We would expect it probably will be about half an hour. Thank you.

[Recess.]

Chairman STARK [Presiding]. Thank you. The Committee will reconvene, and I apologize for the interruption.

Mr. Becerra, would you like to inquire? Let me also suggest that for this panel and the next panel, I understand there are some travel plans. If anybody has to leave, please leave without—just absent yourself when you must to make your travel connections.

Mr. BECERRA. Thank you, Mr. Chairman. To the panelists, thank you very much for being so patient with us here.

Let me see if I can get some general background real quickly. Does anyone in the panel here believe that there is something special or particular about these Private Fee-for-Service plans that makes them so attractive to the industry today, other than the fact that you are able to get more reimbursement from Medicare for the services you are about to provide?

Ms. SCHMITT. Could you expand on your question specifically?

Mr. BECERRA. We have seen such a migration, rapid migration, toward these Private Fee-for-Service plans, a massive increase, in the thousands of percentage increase, in a short period of time. It is not that they are now doctors. It is not that we found some new innovations in health care. It is not that there are new therapies and drugs that are going to be used under Private Fee-for-Service

that would not be used under traditional fee-for-service or by the regular HMO plans.

Something is driving the industry to want to use Private Fee-for-Service. I am trying to find out if anyone could explain to me if there is anything other than the fact that there is a better, a richer reimbursement for the product or service you are about to offer a senior on Medicare.

Ms. SCHMITT. Well, we believe that it really does provide a service opportunity to beneficiaries. If you keep in mind before MA Private Fee-for-Service, members had a Medicare identification card. Then they had a private carrier supplemental card. Then they were introduced with a Part D card.

We find that our beneficiaries like the idea that they are able to carry a single Blue Cross card that provides all of their care, where they can get all of their services taken care of. They like——

Mr. BECERRA. So, Ms. Schmitt, if Blue Cross Blue Shield were to offer all of these different services, and if Private Fee-for-Service did not exist, would you go ahead and offer these services without a Private Fee-for-Service plan?

Ms. SCHMITT. Are you asking me would we offer an HMO or PPO option?

Mr. BECERRA. You have just said that one of the attractions is that you can avoid having three separate cards, one for regular Medicare services, one for your Medigap coverage, and one for your prescription drug coverage. Without Private Fee-for-Service, you would not try to provide those three services within one shop within Blue Cross Blue Shield?

Ms. SCHMITT. Well, there are regulations around what you can combine and what you can do. It is not that easy without having the integration available through the MA Private——

Mr. BECERRA. So, if we made the integration possible but we didn't offer the money, would you still do it?

Ms. SCHMITT. It would—we would have to look at all of the rules and requirements. Could we do the care management? Could we share the data that is available for prescription drugs?

Mr. BECERRA. So, there are some regulations that you are liberated from having to follow under the Private Fee-for-Service model that you see as preferable to the traditional Medicare fee-for-service or the regular HMO service under Medicare advantage?

Ms. SCHMITT. We would clearly have to look at the entire business model and determine if it is sustainable.

Mr. BECERRA. I hope you will because you haven't clarified anything by not being able to give me more specifics. It leaves me with the conclusion that it is the money, that you are getting more money to offer services. You can offer a few more services because you are getting a lot more money.

Until someone can tell me otherwise—or perhaps it is regulations, the lack of regulations that makes it attractive to go into these Private Fee-for-Service plans, but I see nothing to show that there is a reason why we have seen such a dramatic migration toward Private Fee-for-Service except for the fact that there is a bigger dollar for the requirement of services that you need to provide.

Dr. Neuman, you wanted to say something?

Mr. CAMP. Well, if gentleman would yield, I think she said there were regulatory issues involved as well. So, I just think, to be fair to the witness——

Mr. BECERRA. Right. I asked her if it were a loosening of regulations, then would that be okay? Would they still then provide that service if we had no Private Fee-for-Service? Ms. Schmitt said, I believe, that she would still have to take a look.

Ms. SCHMITT. Well, but do keep in mind, part of the problem that we have is that Medicare is paying the primary claim, and then later on we get a supplemental claim, and then you are trying to do care management. That whole model of being able to deliver the care management is—I don't know. I would need to see whether or not it could even be put together.

Mr. BECERRA. That is fair. That is fair, but again, you are not talking about the money. So, I am assuming that the money is not what is driving Blue Cross Blue Shield in Michigan toward this Private Fee-for-Service model, from your testimony.

Ms. SCHMITT. There is a cost for some of the added services.

Mr. BECERRA. I know my time has expired, but perhaps, Dr. Neuman you might—no? Okay. Thank you.

Well, Mr. Chairman, I know my time is expired and I will yield back.

Chairman STARK. I guess the only person I can ask this of is Ms. Schmitt. You may want to respond at a later date. We may have to make some adjustments in MA plans. We may have to make some adjustments of what we pay hospitals, doctors, and everybody else, before we are done to keep the Medicare plan fiscally sound, financially sound.

My suspicion is from what we know, certainly anecdotally, there is a wide variety in MA plans, both in terms of what we pay them relative to fee-for-service and in what kind of benefits they provide or offer. We have no idea of how many people use them. It is one thing to offer a benefit, but if nobody takes it, it obviously is a great benefit to offer because it doesn't cost the plan any money.

How would you suggest, as I have said to some of the plans in my district, that we sort the wheat from the chaff? The plans have been rather reluctant to give us any detailed information, which is their right, I guess, to keep everything secret, but if we don't know, if we don't really have the details of how to differentiate, then the only option open to us is across-the-board cuts. I have never thought those were the fairest way to achieve savings.

So, what would you suggest that we look at? Loss ratios? Standardized benefits? Cost of benefits? How would you like to be measured against your competitors, say? What is the area that you think we should rank plans on? Any ideas on that?

Ms. SCHMITT. Well, I will take your first option to get back to you, but in the meantime off the top of my head, I do believe the market is going to very quickly sort out those plans where members are not feeling that they are getting——

Chairman STARK. I am not talking about the market because the people you are selling to don't know that the taxpayers are paying plans a substantial amount over fee-for-service. So, what I am suggesting is that some plans are getting as high as 150 percent

of fee-for-service. Some maybe getting 102, 104 percent of fee-for-service.

We are unable to get that into focus in terms of what do we get? What are we getting for the extra 2, 4, or 50 percent? If we were to say, if you eliminated the plans completely we would save the taxpayers 50-, $60 billion over 5 years, well, what about if we just eliminated the least efficient plans? How would we determine that? As people who set the rates that are paid to plans, how can we better distinguish between the plans? Any ideas? Not what you sell to the public because that has no relationship often to what Medicare is paying you.

Ms. SCHMITT. As I mentioned in my testimony, I think that it is very reasonable for you to expect that the Private Fee-for-Service plans do have care management features the same, and that they do meet some of the other requirements that are there so that you do have a more equal playing field between the plans. I think it is very reasonable.

Chairman STARK. Versus perhaps standardizing benefits?

Ms. SCHMITT. I don't believe in standardizing benefits. Let me give you a couple reasons.

Chairman STARK. Well, how about standardizing them as we did, say, in Medigap? So, we started with a dozen plans.

Ms. SCHMITT. Well, what was mentioned about the Medigap, I think there is one very significant difference. That is individual beneficiaries were able to enroll in multiple Medigap plans, not realizing that they had the same benefits overlapping; where with MA, a person can only be enrolled in either traditional Medicare or one MA plan.

So, I don't know that it is the same situation that they started with. Also, the Medigap plans did evolve for a number of years before it was determined what appropriate standard benefits are. So, A, I don't think it is the right solution; but even if it were, I think it needs to play out a little longer before anyone could really say, this is the right set of benefits or the right combination of benefits.

Chairman STARK. I am just asking for your advice as to how we determine which plans are more worthy of taxpayers' dollars than others because arguably some are getting bigger spreads, bigger margins than others. We are looking for a way hopefully to determine which are better plans than others. You might think about it, and we would certainly appreciate any advice you could give us.

Ms. SCHMITT. Thank you.

Chairman STARK. I want to thank all of you for waiting for us. I apologize for keeping you here for this extra length of time while we voted.

We will dismiss this panel, and our next panel will be comprised of—and I don't know whether Mark—did he leave?

[The prepared statement of Mr. Miller follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Private Fee-for-Service Plans in Medicare Advantage

May 22, 2007

Statement of
Mark E. Miller, Ph.D.

Executive Director
Medicare Payment Advisory Commission

Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Glenn M. Hackbarth, J.D., Chairman • Robert D. Reischauer, Ph.D., Vice Chairman • Mark E. Miller, Ph.D., Executive Director
601 New Jersey Avenue, NW • Suite 9000 • Washington, DC 20001 • 202-220-3700 • Fax: 202-220-3759 • www.medpac.gov

Chairman Stark, Ranking Member Camp, distinguished Subcommittee members, I am Mark Miller, Executive Director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this afternoon to discuss Medicare Advantage (MA) private fee-for-service (PFFS) plans.

MedPAC is charged by the Congress with making recommendations on payment policy both for providers in Medicare's traditional fee-for-service (FFS) program and for MA organizations. The Commission's goal is for Medicare payments to cover the costs that efficient providers and organizations incur in furnishing care to beneficiaries, while ensuring that providers are paid fairly and that beneficiaries have access to the care they need. MedPAC focuses on ensuring that Medicare program dollars are spent wisely—ensuring that beneficiaries receive efficient, high-quality care and that beneficiaries and taxpayers get maximum value for each dollar spent in the program. We are striving to make Medicare a more efficient program while improving the quality of care beneficiaries receive. This is our framework for making recommendations on payment policy for providers in FFS Medicare; it is the same framework we use in making recommendations on MA payment policy.

The Commission supports the participation of private health plans in Medicare. Beneficiaries should be able to choose health plans that seek greater efficiency in the delivery of health care and improved outcomes for enrollees. Private plans have the flexibility to use care management techniques that FFS Medicare does not encourage. When private plans are paid appropriately, they have greater incentives to undertake innovations in care delivery and management and to negotiate with providers over levels and methods of payment. The Commission believes that the MA program as currently structured is not promoting greater efficiency because plans are not being paid appropriately.

The current MA payment policy is inconsistent with MedPAC's principles of payment equity between MA and the traditional FFS program. The Commission believes that payment policy in the MA program should be built on a foundation of financial neutrality between payments in the traditional FFS program and payments to private plans. Financial neutrality means that the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses. Moreover, the

program applies the standards and rules inequitably among different types of MA plans. Equity and efficiency issues are of particular concern with Medicare facing long-run issues of financial sustainability, discussed in our March 2007 report to the Congress.

MedPAC recommendation on MA payment

Medicare's private plan option was originally designed to produce efficiency in the delivery of health care, to the benefit of both the program and plan enrollees. Efficient plans would be able to provide extra benefits to enrollees, and greater efficiency would lead to higher plan enrollment. Competition among plans for enrollees would promote further efficiency.

Although MA uses a type of bidding system to determine plan payments and beneficiary premiums, the MA payment system does not promote efficiency because MA plans are bidding against benchmarks that have been set at very high levels through various legislative changes. As a result, plans that are more costly than traditional Medicare can attract enrollment by offering extra benefits financed by the higher payments. Inefficient plans—as well as efficient plans—are able to provide enhanced coverage. The enhanced coverage is possible because of generous MA program payments in excess of Medicare FFS payment levels.

Beginning with our March 2001 report to the Congress, the Commission has recommended that Medicare payment policy should be neutral to whether a beneficiary chooses a private plan or remains in the traditional FFS program. What this means for MA payment policy is that benchmarks—the basis of payment in MA—should be set at 100 percent of FFS Medicare rates.

To say that MA benchmarks should be at 100 percent of Medicare FFS expenditures does not mean the Commission considers the traditional FFS program to be the "gold standard" of efficiency—either in terms of program costs or in terms of the value beneficiaries receive for each dollar of program expenditures. In FFS, we know that, among providers and across geographic areas, there are varying levels of efficiency and varying levels of quality. The same is true of MA health plans. Efficiency and quality vary across plans and across plan types. The Commission's recommendation that MA benchmarks be set at 100 percent of FFS

would allow plans that are efficient, relative to FFS Medicare, to participate successfully in Medicare and offer enrollees extra benefits financed by plan efficiencies.

Having recommended that benchmarks be set at 100 percent of FFS, the Commission also recognizes that changing MA plan payment rates to achieve financial neutrality too quickly will cause disruptions for beneficiaries in some markets, and thus the Congress may want a transition period as payment changes are made.

PFFS plans: Enrollment growth, payment levels, and their efficiency

PFFS plans were authorized in the Balanced Budget Act of 1997 (BBA), but it has only been recently that enrollment has grown in these plans. In December 2005, there were about 200,000 PFFS enrollees, and Medicare had contracts with 17 PFFS plans. As of February 2007 there were 47 contracts and the PFFS plans had about 1.3 million enrollees—a growth rate of nearly 300 percent over a year and a half, or 1.1 million new enrollees (Table 1).

Table 1 Private fee-for-service plan enrollment has grown at a faster rate than other types of Medicare Advantage plans in the last two years

Plan type	Enrollment			Net enrollment growth	
	December 2005	August 2006	February 2007	Dec. 2005 to Aug. 2006	Aug. 2006 to Feb. 2007
Local HMOs and PPOs	5,157,627	5,921,837	6,064,666	15%	2%
PFFS	208,990	802,068	1,327,826	284%	66%
Regional PPOs	None available	89,492	120,770	N/A	35%

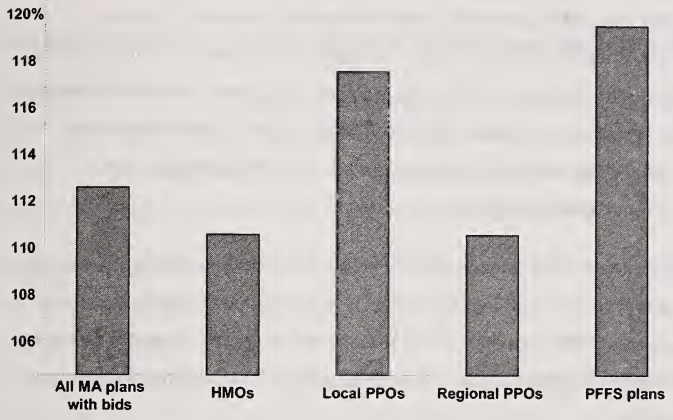
Note: PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not applicable).

Source: CMS enrollment data.

The remarkable growth in PFFS enrollment is due to a number of factors, with the primary factor being MA payment policy. Currently, all plan types receive MA program payments for their enrollees that, on average, are greater than program expenditures would have been if the beneficiaries had remained in FFS Medicare. Among plan types, PFFS plans have the highest ratio of plan payments to Medicare FFS expenditures—not because they are paid differently but because of where they operate and the counties where they have enrollment and because of the costs they incur in providing the Medicare benefit package, as I explain below. On

average, for PFFS enrollees, the program spends 119 percent of what the program would have spent in FFS Medicare (Figure 1).

Figure 1 PFFS plans, on average, have the highest relative percentage of MA plan payments compared to Medicare FFS spending



Note: PFFS (private fee-for-service), MA (Medicare Advantage), FFS (fee-for-service), PPO (preferred provider organization). Data are enrollment-weighted numbers as of July 2006.

Source: MedPAC analysis of CMS bid data.

MA benchmarks and plan payments

Figure 1 represent the payments to each plan type for both the Medicare Part A and Part B benefit package and the extra benefits that MA plans will provide, as determined through the MA bidding system that began in 2006.

Under the MA bidding system, payments to MA plans are based on benchmarks for each county or, in the case of regional preferred provider organization (PPO) plans, benchmarks for each region. The benchmarks are bidding targets for the plans. The benchmark is the maximum amount Medicare will pay an MA plan. Any other revenue that the plan needs to cover the cost of providing the Medicare benefit package to its enrollees has to come from beneficiaries—in the form of a plan premium or cost sharing for plan services.

To determine beneficiary premiums and to determine the amount Medicare will pay a plan, plans give CMS a bid stating what it will cost the plan to provide the Medicare Part A and Part B benefit package. If the plan bid exceeds the benchmark, the plan charges a premium to make up the revenue it needs to cover the cost of providing the Medicare benefit package. If a plan bid for the Medicare benefit package is below the benchmark, 25 percent of the difference is retained in the Medicare trust funds, and the plan is required to use the remaining 75 percent, referred to as the "rebate," to finance extra benefits, such as reduced Part B or Part D premiums, reduced cost sharing, or added benefits not covered by Medicare (e.g., routine vision and dental coverage). Plan bids for all benefits—both the Medicare Part A and Part B benefit package and extra benefits—include costs for administration, marketing, and profit or retained earnings.

Virtually all plans participating in MA are bidding below their area benchmarks. In part, this is because benchmarks are very high in relation to FFS as a result of a number of statutory provisions introduced over the years that affected benchmark levels. For example, statutory provisions introduced minimum county payment rates, or floors, intended to attract or retain private plans in Medicare.

The effect of floor payment rates on MA benchmarks

Payment floors were introduced in the BBA in 1997. The BBA established a payment floor for counties with relatively low FFS expenditures. The BBA floor is often called the rural floor because it applies mainly to rural counties and was primarily intended to attract plans to rural areas. What is referred to as the large urban floor, or the metropolitan statistical area (MSA) floor, applies to counties within large MSAs. The MSA floor was introduced in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and was effective as of March 2001. BIPA also provided an increase in the BBA floor rate. In many cases, the floor rates resulted in plan payment rates that were well above Medicare FFS expenditure levels in a given county.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which introduced the MA program, made changes to the methodology for determining plan payment rates (i.e., the benchmarks, in the bidding system). One aspect of the payment

changes is that there is no longer a payment floor provision in the law. However, the effect of the earlier floors is still seen in MA benchmarks for counties that historically had been floor counties. These counties still have very high relative benchmarks compared with other geographic areas: On average, the benchmarks are 121 percent of FFS for the MSA floor counties and 134 percent of FFS for the floor established in the BBA (mainly rural counties).

MA benchmarks and plan payments: PFFS versus other plans

Enrollment in PFFS tends to be concentrated in counties with benchmarks based on floor rates—i.e., rates that were often significantly higher than FFS expenditure levels for the county. This explains the difference in benchmarks for PFFS plans compared to other plan types in MA, which do not have their enrollment so highly concentrated in floor counties.

In July 2006, about 87 percent of PFFS enrollment was in floor counties. Consequently, the July 2006 enrollment-weighted level of benchmarks for PFFS plans was at 122 percent of FFS. The high benchmarks allow PFFS plans to have high bids that enable these plans to finance their cost of providing the Medicare Part A and Part B benefit. The Medicare program pays, on average, 109 percent of FFS for each enrollee for a PFFS plan to provide the Medicare Part A and Part B benefit package—making PFFS the least efficient plan type when measured against expenditures in Medicare's traditional FFS program (Table 2). The benchmarks are also high enough that, on average, all plan types—including the least efficient ones—are able to offer extra benefits financed by rebate dollars.

Table 2 PFFS plans are the least efficient plan type in MA

	All MA plans with bids	HMO	Local PPO	Regional PPO	PFFS
Benchmark/FFS expenditures	116%	115%	120%	112%	122%
Bid (for Medicare Part A and Part B benefit) in relation to FFS	99	97	108	103	109
Rebate as percent of FFS	13	13	9	7	10
Payment (bid + rebates)/FFS	112	110	117	110	119

Note: PFFS (private fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), FFS (fee-for-service). Data are for July 2006, weighted by plan enrollment.

Source: MedPAC analysis of CMS bid data.

While PFFS plans are the least efficient plans, HMOs are the most efficient MA plans. That is, for a comparable beneficiary and a comparable benefit package, HMOs deliver the traditional FFS benefits much more efficiently than PFFS plans. HMO plans can provide the Medicare Part A and Part B benefit for 97 percent of Medicare's FFS costs, on average.

When a plan bid is lower than the benchmark, the total program payment to an MA plan consists of the payment of the plan bid for the Part A and Part B benefit plus the rebate dollars (75 percent of the bid-to-benchmark difference). When plan bids are low, more money is available for extra benefits financed by rebate dollars, and more is retained in the trust funds. When looking at Medicare payments to plans—the bid plus the rebate amount—PFFS plans are again the least efficient plan type. The combined program payment, the bid plus rebate dollars, is at 119 percent of FFS for these plans. In contrast, even though HMOs operate in areas with lower average benchmark ratios than PFFS plans, HMOs provide a higher level of extra benefits than PFFS plans—13 percent of FFS expenditures for HMOs versus 10 percent of FFS for PFFS plans—and they do so with better overall efficiency. That is, HMOs provide the Medicare Part A and Part B benefit package, and extra benefits, at a far lower total program cost (110 percent of FFS) than PFFS plans (119 percent of FFS).

While the Commission has recommended that benchmarks be set at 100 percent of FFS, the Commission also recommended in the June 2005 report to the Congress that the 25 percent difference between the benchmark amount and bids below 100 percent of the benchmark that is currently retained in the Medicare trust funds should be used to fund a pay-for-

performance program in MA. (Note that, for regional PPO plans, one-half of the 25 percent difference is reserved in a stabilization fund that can be used to promote regional PPO participation, but the funds are not available until 2012.)

PFFS plans: Their history and how they differ from other MA plans

In addition to differing from other plan types in their level of efficiency, PFFS plans differ in many other ways, including in their plan structure; the statutory, regulatory, and administrative requirements applicable to these plans; and the historical basis for including PFFS plans as a Medicare option.

To understand the role of PFFS plans in Medicare, and how that role has changed in the MA program, I will review some of the history of private plan contracting in Medicare and the history of the PFFS option in particular.

Within the MA program, there are several types of plan options, with different features that might attract beneficiaries looking at their options in terms of cost (or cost savings), quality, and plan features. The current MA options range from HMOs that use staff or group practices or have other network arrangements; to HMOs with point-of-service options that cover some level of out-of-network care; to PPOs that have in-network as well as out-of-network coverage; to the least restrictive option, PFFS plans; and other options such as cost-reimbursed plans and medical savings account plans.

The law defines a PFFS plan as one in which the plan, "(A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; (B) does not vary such rates for such a provider based on utilization relating to such provider; and (C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan" (section 1859(b)(2) of the Social Security Act).

Although the statute permits PFFS plans to form networks of providers paid on a FFS basis, to date virtually all PFFS plans are paying providers at Medicare FFS rates and have not

formed networks. Instead, PFFS plans rely mainly on "deemed" participation of providers to provide care to their enrollees. Under this policy, the plan deems a provider to be in the PFFS plan if the beneficiary states that he or she is a PFFS plan enrollee and the provider treats the patient after learning about the plan's terms and conditions of payment. A provider also is deemed if he or she has had reasonable opportunity to obtain information about terms and conditions (such as being provided with an Internet source for the terms and conditions). PFFS plans essentially mimic FFS Medicare in their structure and their payment and contracting arrangements with providers.

The BBA introduced the PFFS option to allow for a private plan that guaranteed access to all Medicare providers without imposing utilization controls on the providers. Policymakers developed this option because, in the 1990s, during the period of greatest growth in managed care enrollment, they feared that there could be rationing of health care as a result of the general movement toward managed care, utilization management, and restrictive provider networks in the health care system. They wanted an option without limitations on enrollees' ability to obtain care through the providers of their choice.

While including the PFFS option in the BBA, the Congress also intended that enrollees bear the added cost of a private health plan offering free access to providers. As noted in the BBA conference report, "the private fee-for-service Medicare+Choice option authorized by this agreement represents the first defined contribution plan in which beneficiaries may enroll in the history of the program." PFFS was a defined contribution plan under Medicare+Choice (the predecessor to MA) because, unlike other plans, a PFFS plan could charge a premium for its cost of providing the Medicare Part A and Part B benefit package in excess of the actuarial value of Part A and Part B cost sharing in FFS Medicare. That is, the Congress expected PFFS plans to be more expensive than FFS Medicare. Beneficiary premiums would make up the shortfall in revenue, and beneficiaries would be willing to pay an extra premium to guarantee what the beneficiary would consider adequate access to providers and adequate access to Medicare-covered services. Currently, PFFS plans are more expensive than the traditional FFS program, but the Medicare program, not the beneficiaries enrolling in these plans, pays the difference in cost. Medicare is subsidizing these plans for both the cost of the Medicare benefit package as well as the cost of extra benefits.

The payment floors created an opportunity for PFFS plans to play a different role from what was envisioned for these plans in 1997. The current MA benchmarks are high enough to permit PFFS plans to cover their cost of providing the Medicare Part A and Part B benefit and high enough to allow the plans to offer extra benefits to enrollees. Because floor payments in rural areas and certain MSA counties are so far above Medicare FFS expenditure levels, PFFS plans have been able to operate as non-network plans, pay FFS Medicare rates to providers, *and* offer reduced cost sharing and extra benefits to enrollees. If benchmarks were not so high, it is unlikely that PFFS plans would be attractive for beneficiaries. PFFS plans do not use the mechanisms that managed care plans use to increase efficiency (e.g., formation of networks, careful utilization controls) and therefore would not be able to offer attractive benefit packages if MA benchmarks were closer to Medicare FFS expenditure levels.

The high MA benchmarks have allowed PFFS plans to attract enrollment in areas with limited competition from other plan types. In certain types of geographic areas, PFFS plans have an advantage over other MA plan types that must set up networks of providers. In rural areas, for example, there are many barriers to setting up networks, which the Commission documented in a June 2001 report to the Congress. In the same report, we anticipated the possibility that PFFS plans would be providing extra benefits solely because of the higher payment rates and noted that this "would not appear to be paying the cost of an efficient provider—the basic axiom of Medicare payment policy. Paying PFFS plans at ... [higher] rate[s] is an expensive way to get extra benefits for Medicare beneficiaries in some counties."

Advantages enjoyed by PFFS plans compared to other plans

In addition to their non-network structure and the ability to piggyback on Medicare rates to pay providers, PFFS plans have an advantage over other MA plans because they are subject to fewer requirements, and certain statutory and administrative rules provide additional advantages to these plans. The differences are outlined in Table 3.

The Commission supports equity in the treatment of different plan types within the private plan sector. The Commission favors a level playing field for all plan types, with no type having an advantage over another type unless special circumstances dictate otherwise. The

Commission believes, for example, that PFFS plans should report on the quality of care for their enrollees so that beneficiaries can use quality as a factor in judging these plans.

Table 3 Different requirements and provisions apply to different types of MA plans

	PFFS	Medical Savings Account	HMO/ Local PPO	Regional PPO	SNP
Must build networks of providers[a]			✓	✓	✓
Must report quality measures			✓	✓	✓
Must have bids reviewed and negotiated by CMS			✓	✓	✓
Protected from some risk through risk corridors[b]				✓	
Must return to the trust funds 25 percent of the difference between bid and benchmark[c]	✓		✓	✓	✓
Must offer Part D coverage[d]			✓	✓	✓
Must have an out-of-pocket limit on enrollee expenditures		✓		✓	
Can limit enrollment to targeted beneficiaries[e]					✓
Must offer individual MA plan if offering employer group plan[f]			✓	✓	✓

Note: MA (Medicare Advantage), PFFS (private fee-for-service), PPO (preferred provider organization), SNP (special needs plan).

[a]PFFS plans are exempted from other MA plans' network adequacy requirements if they pay providers Medicare fee-for-service rates.

[b]Risk corridors are available only in 2006 and 2007.

[c]This provision applies when bids are under the benchmark. For regional PPO plans, one-half of the 25 percent amount is retained, and the remainder is included in the stabilization fund that, as of 2012, may be used to retain or attract such plans.

[d]Medical savings account plans are prohibited from offering Part D coverage. PFFS plans may offer Part D coverage, but special rules apply to such plans (e.g., it is not required that they receive drugs at a discounted rate when the deductible applies or the person is in the Part D coverage gap).

[e]MA plans must allow all Medicare beneficiaries in their service area to enroll with few exceptions (e.g., beneficiaries with end-stage renal disease). Other exceptions apply to medical savings account plans (e.g., Medicaid beneficiaries may not enroll in such plans). SNPs are permitted to limit their enrollment to their targeted beneficiary population (i.e., dual eligibles, beneficiaries who reside in an institution, or those with a chronic or disabling condition). SNPs can be local or regional coordinated care plans. They cannot be medical savings account or PFFS plans.

[f]Only non-network PFFS plans can operate exclusively as plans limited to employer group enrollees.

To highlight another major difference from other plan types, PFFS plans (and medical savings account plans) will have an advantage in their ability to offer retiree coverage to an

employer or union for the entity's Medicare population. Other types of organizations with network plans that wish to offer plans tailored for employer-group-sponsored retirees must have plans that are available to individual, non-group-sponsored beneficiaries (i.e., to have a group contract they must also be operating in the individual Medicare market). As of 2008, non-network PFFS plans and medical savings account plans will not have this requirement, so they will be able to offer plans exclusively to employers or unions.

The Commission is also concerned about a recent statutory provision that gives an unfair advantage to PFFS plans. The Tax Relief and Health Care Act of 2006 added a provision, effective only for 2007 and 2008, which allows a beneficiary who is not an MA enrollee (i.e., is in FFS Medicare) to enroll in an MA-only (nondrug) plan outside of the open enrollment period. These MA-only plans can thus have year-round enrollment, while other plans may accept new enrollees only during the open enrollment period (or if a person is newly entitled to Medicare, or is a dual eligible). In particular, the provision gives an advantage to PFFS plans. The CMS guidance on this provision states that beneficiaries will lose their Part D coverage in a stand-alone drug plan if they take this option and enroll in an MA organization that has drug coverage (an organization with an MA–Prescription Drug option). In effect, if such a person wishes to continue Part D drug coverage and wants to enroll in MA, the only available option is a PFFS plan not offering drug coverage. Beneficiaries without drug coverage may enroll in any MA-only plan, but people with Part D coverage would have the drug coverage continue only if they enroll in a PFFS MA-only plan.

Conclusion: FFS Medicare, MA, and PFFS plans

In MA, plans compete against the traditional program to attract enrollees, and plans in a given market area compete against each other to attract enrollees. MA plans distinguish themselves from traditional FFS Medicare, and from other competing plans, on the basis of reduced cost and added benefits, quality, and other features that beneficiaries find attractive.

PFFS plans were designed to meet a perceived need. As originally conceived, the Congress did not expect that PFFS plans would be able to offer reduced costs or extra benefits to enrollees choosing the option. In fact, PFFS plans were expected to have additional

premiums that enrollees would have to pay. What would attract beneficiaries to PFFS plans would be the assurance that they could receive care through an FFS system where providers were not subject to utilization controls.

The current MA payment system has set up the wrong market dynamic. Setting benchmarks well above the cost of traditional Medicare signals that the program welcomes plans that are more costly than traditional Medicare. Both PFFS plans, which are inefficient when measured against FFS program costs, as well as other types of MA plans that are efficient, provide the kind of enhanced coverage that attracts beneficiaries to private plans. In many cases, generous MA program payments that are in excess of Medicare FFS payment levels are financing these benefits. All taxpayers, and all Medicare beneficiaries—not just the 18 percent of beneficiaries enrolled in private plans—are funding the MA payments in excess of Medicare FFS levels.

The current MA payment policy is inconsistent with MedPAC's principles of payment equity between MA and the traditional FFS program. Moreover, the program applies the standards and rules inequitably among different types of MA plans. Equity and efficiency issues are of particular concern with Medicare facing long-run issues of financial sustainability.

The Commission believes that the Medicare program achieves greater efficiency when organizations face financial pressure. The Medicare program needs to exert consistent financial pressure on both the traditional FFS program and the MA program. This financial pressure, coupled with meaningful measurement of quality and resource use to reward efficient care, will maximize the value of Medicare for the taxpayers and beneficiaries who finance the program. The current MA payment policy is not exerting the kind of financial pressure that can maximize efficiency. MA payment policy is actively shaping the market for Medicare health plans, but the current policy conveys the message that Medicare values private plans that cost more than FFS, and Medicare is willing to subsidize beneficiary enrollment in MA.

So, we will now hear from CMS and Ms. Abby Block. Having saved the best for last, we will find out what information Ms. Block has to favor us with.

Ms. Block, thank you for your patience and we have your prepared testimony, which will appear in the record in its entirety—Perhaps you would like to summarize your testimony and/or comment if you will—if you would like on any of the testimony in the previous panel.

STATEMENT OF ABBY L. BLOCK, CENTER FOR BENEFICIARY CHOICE, CENTERS FOR MEDICARE AND MEDICAL SERVICES

Ms. BLOCK. I think I will start with reading my oral statement and then I am sure there will be questions and we can proceed with the dialog.

Chairman STARK. Please.

Ms. BLOCK. Good afternoon, it is still afternoon. Chairman Stark and Ranking Member Camp and distinguished Members of the Subcommittee, thank you for inviting me here today to discuss MA Private Fee-for-Service Plans. MA offers an affordable high value-choice in comprehensive health care coverage for all Medicare beneficiaries. As you know, this program is a valued important option for millions of people with Medicare. Working closely with Congress, and this Subcommittee in particular, we have refined MA over the years to promote strong plan participation across the country. With a vibrant marketplace of plans for 2007, beneficiary enrollment is now at an all-time high and plans are available in every State across the country, including rural areas. In particular, growth in Private Fee-for-Service plan offerings has been a key factor in expanding access to MA plans for rural beneficiaries. At the same time, a majority of beneficiary complaints regarding MA are about Private Fee-for-Service plans and the way they have been marketed. For these reasons, CMS appreciates your interest in looking carefully at this segment of the MA market.

It is important to note that Private Fee-for-Service differs in several ways from other MA products. Key differences are the statutory exemptions from quality reporting and CMS bid review, as well as the requirement to offer at least one option with Medicare prescription drug coverage as other MA plans are required to do. As you know, Private Fee-for-Service plans were authorized by the Balanced Budget Act (P.L. 105–33). Generally, they were intended to be less restrictive as a type of private plan than the HMO model plans that were available under risk contracting until then. While traditional HMO model plans rely on gatekeepers and a closed network of providers, the Private Fee-for-Service model gives enrollees greater flexibility in choosing and accessing providers.

Although the Medicare law permits Private Fee-for-Service plans to meet access requirements by entering into written contracts with a network of providers and permits Private Fee-for-Service plans to negotiate lower reimbursement rates for such network providers, virtually none of the existing Private Fee-for-Service plans have opted for that approach. Instead, they operate under the provision of the law that provides that Private Fee-for-Service plans are deemed to have a contract in place with any provider eligible to provide Medicare-covered services if that provider is given an op-

portunity to get information on the Private Fee-for-Service plan's payment terms and conditions and agrees to provide services to the plan's enrollees.

Enrollees in these plans can go to any provider in the United States eligible to bill Medicare and willing to accept their plan's payment terms. They will pay the same cost sharing regardless of which provider they see. In contrast to coordinated care plans, a sponsor may offer a MA-only Private Fee-for-Service plan, which does not include Part D coverage as its only option. Beneficiaries enrolled in MA-only Private Fee-for-Service plans also may enroll in a stand-alone prescription drug plan. Over 60 percent of Private Fee-for-Service plan enrollees are in a plan that includes Part D coverage. The others may be receiving prescription drug coverage from other sources, such as a former employer or union.

While the overwhelming majority of MA enrollment is in coordinated care plans, such as HMOs and PPOs, Private Fee-for-Service plan enrollment current comprises about 18 percent of total MA enrollment. Although initial enrollment in Private Fee-for-Service plans was low, growth has been very strong in the last 2 years with enrollment reaching over 1.3 million, excluding employer plans or 1.55 million in total for 2007.

Recent rapid growth in Private Fee-for-Service enrollment may be a reflection of the perceived value of this product to beneficiaries, particularly in rural areas. Fifty-9 percent of all MA enrollees in rural areas are in Private Fee-for-Service plans.

The Private Fee-for-Service product because it is typically not network-based also offers a particular advantage to employers who want to cover their retirees regardless of where they live. The percentage of Private Fee-for-Service enrollees in employer-sponsored plans increased from 5 percent in 2006 to 15 percent in 2007. Like other MA enrollees, Private Fee-for-Service plan enrollees can receive benefits beyond what traditional Medicare provides. On average, Private Fee-for-Service plan enrollees receive about $63 per month in additional benefits. As referenced in the handout you were given and on page seven of my written statement, there is a chart outlining the specific benefits to which Private Fee-for-Service beneficiaries have access. The rapid growth of Private Fee-for-Service in recent years has raised some concerns. One issue is that the Medicare Program pays more for beneficiaries enrolled in MA plans, including Private Fee-for-Service, than it would if they stayed in original Medicare. By statute, 75 percent of the difference between a plan's bid and the benchmark must be returned to plan enrollees in the form of additional benefits, including lower cost sharing. The other 25 percent remains in the treasury. However, on average Private Fee-for-Service plan bids are higher than local coordinated care plan bids or than MA plan bids in general.

While Private Fee-for-Service plans provide valuable additional benefits to many enrollees, the average monthly dollar value of additional benefits provided is lower than the $86 dollar average for all MA enrollees. Second, as I mentioned earlier, Medicare law explicitly exempts Private Fee-for-Service plans from most of the quality assessment and reporting requirements that MA-coordinated care plans must meet. Many of the requirements were designed with network-based plans in mind, making certain types of

reporting difficult for Private Fee-for-Service plans. However, a handful of plans have reported voluntarily and we are encouraging all plans to report quality data so that they can be included in our 2008 quality reporting initiatives.

Finally, there have been numerous complaints about the marketing practices of Private Fee-for-Service plans and enrollee issues with access to services. As described in my written testimony, CMS takes these concerns very seriously and we are taking steps to ensure that beneficiaries are protected and that they, as well as providers, better understand the Private Fee-for-Service product.

Mr. Chairman, thank you again for this opportunity to testify regarding Medicare Private Fee-for-Service plans. I would be happy to answer any of your questions. I think in my statement I have in fact addressed some of the issues that were raised by some of the previous panel, and I think I would like to stop for some water if you wouldn't mind.

[The prepared statement of Ms. Block follows:]

Testimony of
Abby L. Block
Director, Center for Beneficiary Choices
Centers for Medicare & Medicaid Services
Before the
House Ways & Means Subcommittee on Health
On
Medicare Advantage Private Fee-For-Service Plans
May 22, 2007

Chairman Stark, Ranking Member Camp and members of the Subcommittee, thank you for inviting me here today to discuss Medicare Advantage Private Fee-for-Service (PFFS) plans. Medicare Advantage offers an affordable, high value-choice in comprehensive health care coverage for all Medicare beneficiaries. Enrollment in Medicare Advantage is now at an all-time high and plans are available in every state across the country, including rural areas. Growth in PFFS plan offerings has been a key factor in expanded access to MA plans for rural beneficiaries. At the same time, a majority of beneficiary complaints regarding Medicare Advantage are tied to PFFS plans and the way they have been marketed. For these reasons, the Centers for Medicare & Medicaid Services (CMS) appreciates your efforts to look at this segment of the Medicare Advantage market, and I am pleased to be here today.

My testimony will focus primarily on the facts related to PFFS plans: the background and current benefit structure of PFFS plans, enrollment trends, and examples of the extra benefits that PFFS plans provide, as well as some of the issues associated with PFFS plans. I will then highlight a number of steps CMS has taken to address concerns we are hearing about PFFS plans, particularly in the areas of marketing oversight and beneficiary and provider education.

Background

Medicare has a long history of offering alternatives to the traditional Medicare fee-for-service (Original Medicare) program. In the 1970's, Congress authorized Medicare risk contracting with managed care plans, and in the 1980's further modified the program to make it more attractive to managed care companies and the Medicare beneficiaries they serve. Under that program, health maintenance organizations (HMOs) contracted with Medicare to provide the full range of Medicare benefits in return for monthly "per person" or "capitated" payment rates. In the Balanced Budget Act of 1997 (BBA), Congress created the Medicare+Choice program to provide more health care choices for Medicare beneficiaries beyond HMO plans. In addition, the BBA corrected perceived flaws in the risk contracting program, including significant payment differences across geographic areas. In 1997, there was well over a three-fold difference between the highest and lowest county payment rates, which were $767 and $221. Since then, Congress has continued to refine the program, which is now called "Medicare Advantage" as specified under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).[1]

The BBA authorized PFFS plans and other new options. PFFS plans generally represented a less restrictive type of private plan option than the HMO plans that had been available under risk contracting. While traditional HMO-model plans rely on a closed network of providers and a primary care "gatekeeper" model, the PFFS plan model allows enrollees greater flexibility in choosing and accessing providers. In addition, the PFFS plan, along with preferred provider organizations (PPOs) and medical savings accounts (MSAs), were an expanded continuum of

[1] For consistency, we will use the term "Medicare Advantage" or MA throughout the testimony rather than Medicare+Choice or other superseded names.

potential Medicare plan designs. With more options, it was hoped that a higher level of plan penetration could be achieved in historically underserved areas. Finally, due to a statutory provision exempting these plans from any limit on premiums that they can charge enrollees, PFFS responded to beneficiary interest in the availability of a potentially higher-cost option that would allow enrollees to receive care to extend life as long as possible.

Although the Medicare law permits PFFS plans to meet access requirements by entering into written contracts with a network of providers, and to impose lower cost sharing for such network providers, existing PFFS plans generally have not opted for this approach. Regardless of whether written contracts are signed with a network of providers, the law provides that PFFS plans are "deemed" to have a contract in place with any provider eligible to provide Medicare-covered services if that provider is provided with an opportunity to get information on the PFFS plan's payment terms and conditions (*e.g.*, if they are set forth on a website), and agrees to provide services to the PFFS plan enrollee. In general, this design allows beneficiaries the option of the value of the MA program (including reduced cost-sharing and additional benefits), with fewer restrictions on their choice of provider than other types of MA plans can offer, and with no prior authorization required to access providers.

The vast majority of PFFS plans have chosen to operate exclusively under the deemed network approach, without entering into written contracts with providers. Enrollees in such plans can go to any provider in the U.S. eligible to bill Medicare who will accept their plan's payment terms, and will pay the same cost-sharing regardless of which provider they choose to see.[2] However,

[2] As noted above, if a PFFS plan has met access requirements through written contracts, it may charge higher cost-sharing for seeing a "deemed" provider.

providers who have not signed written contracts are not required to accept PFFS plan enrollees for treatment as a "deemed" provider, even if the PFFS plan payment amount is equal to or greater than the Original Medicare amount. Providers may at any point up until services are rendered decide not to provide services to a PFFS plan enrollee, even if they previously have agreed to accept that PFFS plan's terms when treating other enrollees of the same PFFS plan, or even if they have agreed to treat that enrollee on earlier occasions. This contrasts with coordinated care plans, where enrollees have the ability to verify with the plan prior to a visit, whether a particular provider is in the network, and where the enrollee thus would be ensured in advance that they would be treated by that network provider.

In contrast to coordinated care plans in Medicare Advantage (*e.g.*, HMOs or PPOs), PFFS plan sponsors are not required to offer at least one option with Medicare prescription drug coverage (Part D). A sponsor may offer a "MA-only" PFFS plan, which does not include Part D coverage, as its only option. Beneficiaries enrolled in MA-only PFFS plans may enroll in a stand-alone prescription drug plan. That said, over 60 percent of PFFS plan enrollees are in a plan that includes Part D coverage. The others may be receiving prescription drug coverage from other sources, such as a former employer.

Enrollment in PFFS Plans

While the overwhelming majority of Medicare Advantage enrollment is in coordinated care plans such as HMOs and PPOs, PFFS plan enrollment currently comprises about 18 percent of total Medicare Advantage enrollment. Initially, few PFFS plans entered the Medicare Advantage program. The first PFFS plan began enrolling beneficiaries in 2000. The year 2004 saw a

noticeable increase in PFFS enrollment, with over 50,000 beneficiaries electing a PFFS plan. Since 2004, growth has been very strong, with enrollment of over 1.3 million, excluding employer-only plans, or 1.55 million in total, for 2007.

Recent rapid growth in PFFS enrollment may be a reflection of improved benefits and value offered to beneficiaries, particularly in rural areas. PFFS plans often locate in areas where Medicare Advantage plans have not traditionally been available. In some states, such as Alaska, Utah, Maine, Idaho and New Hampshire, PFFS plans are the only Medicare Advantage options available in some, if not all, counties. Of the total enrollment in PFFS plans for 2007, 31 percent are beneficiaries from rural areas. Fifty-nine percent of all Medicare Advantage enrollees from rural areas are in PFFS plans.

PFFS plans also are attractive to employers and unions throughout the country, because they can readily provide coverage nationwide, including coverage that is adaptable to seasonal changes in residence. Roughly 15 percent of PFFS enrollment in 2007 derives from employer group and union plans, compared to just 5 percent in 2006. One of the largest additions to PFFS employer group enrollment for 2007 was the Michigan Public School Employees Retirement System, which has close to 100,000 retirees.

Additional Benefits for PFFS Enrollees

Like other Medicare Advantage enrollees, PFFS plan enrollees can receive benefits beyond traditional Medicare. On average, PFFS plan enrollees receive about $63 per month in additional benefits. As is the case for all Medicare Advantage plans, PFFS plans use most of this value to

reduce enrollee cost sharing for Medicare benefits, by reducing the Part D and Part B premiums. Lesser amounts are devoted to providing non-Medicare benefits such as dental and vision care. Nearly half of all Medicare beneficiaries have access to a PFFS plan with no cost sharing for physician visits. Over 90 percent of all beneficiaries have access to a PFFS plan with a copayment of $10 or less for primary care visits, and $20 or less for a specialist visit. With respect to hospital stays, over 50 percent have access to plans with no cost sharing for both long (90-day) and short (6-day) stays.

Beneficiaries enrolled in Original Medicare pay co-insurance of 20 percent of the Medicare-approved amount for most doctor services, and must pay 100 percent of the first $131 yearly for Medicare Part B-covered services or items (including physician visits). In the case of hospital stays, beneficiaries enrolled in Original Medicare pay $992 for days 1-60 in each benefit period; $248 per day for days 61-90 in each benefit period; and $496 per day for days 91-150 in each benefit period. Beneficiaries enrolled in Original Medicare are entitled to "lifetime reserve days" as well – these are 60 extra days of coverage that can be used through a beneficiary's lifetime. Beneficiary cost-sharing for such days currently is $496 per day.

The chart on the next page illustrates some of the benefits beyond Original Medicare that current PFFS plan enrollees enjoy.

Percent of PFFS Beneficiaries Enrolled in PFFS Plans with Specific Attributes	
Benefit Structure	*Percent of PFFS Beneficiaries Enrolled in a PFFS Plan of this Type*
Catastrophic cap between $1,001 and $5,000	**60%**
$1,000 or less for a 90-day hospital stay	**68%**
No premium beyond the Part B premium	**75%**
Unlimited coverage for inpatient hospital days	**77%**
No prior hospitalization requirement before a SNF admission	**83%**
Primary care physician copayments of $20 or less	**85%**
Prostate and cervical and cancer screening with no coinsurance	**88%**

Issues Raised About PFFS Plans

Rapid growth in PFFS enrollment in recent years has raised some issues, generating increased scrutiny of the PFFS option and the ways in which it differs from other Medicare Advantage plan types. Some have raised concerns that the Medicare program pays more for beneficiaries enrolled in Medicare Advantage plans, including PFFS, than it would if the beneficiaries stayed in Original Medicare. Medicare Advantage plans submit bids for the expected costs of delivering Part A and Part B services to plan enrollees.[3] These bids are then compared to plan-specific benchmarks to determine the total payment to plans.[4] By statute, 75 percent of the

[3] The plan bid is each plan's estimate of the cost of delivering Part A and Part B services to the average Medicare beneficiary. It is risk-adjusted based on the characteristics of individual plan enrollees. Pursuant to the Deficit Reduction Act and a CMS announcement in 2005, budget neutral risk adjustment, which had historically increased plan payments, is being phased out. The phase-out began in 2007, with 55 percent of the budget neutrality factor included in plan payments. The phase out will be completed in 2011. In addition, to the extent the plan provides care coordination services, these costs or savings are included as part of their bid.

[4] Benchmarks are the maximum amount Medicare will pay a plan for delivering Part A and B benefits in a specific geographic area; they are determined by the Secretary each year under a methodology provided in the Medicare law. For most plans, benchmarks are based on the county capitation rates used for payment purposes before the bidding system began in 2006. Plan benchmarks are averages of county rates in the plan service area weighted based on projected plan enrollment in each county. (Regional PPO plan benchmarks are based primarily on county capitation rates, but plan bids are also factored in). The vast majority of plan bids are below their respective benchmarks. If a

difference between a plan's bid and the benchmark must be returned to plan enrollees in the form of additional benefits, including lower cost sharing. However, on average, PFFS plan bids are higher than local coordinated care plan bids, or than Medicare Advantage plan bids in general. This difference means that fewer dollars are available for additional benefits, as described below.

The average monthly dollar value of additional benefits provided to PFFS plan enrollees is $63 which is lower than the $86 average for all Medicare Advantage enrollees. Nonetheless, PFFS plans provide valued additional benefits to many enrollees. Some of these beneficiaries have few, if any, other options for additional benefits under the Medicare Advantage program. Others may seek to benefit from the value offered by Medicare Advantage (*e.g.*, reduced cost-sharing and/or additional covered services) while having enhanced flexibility to choose providers as allowed through a PFFS plan.

While on average beneficiaries in PFFS receive $63 per month in additional benefits, in some specific cases, beneficiary cost sharing for certain services may be higher or lower under a PFFS plan than cost sharing under FFS Medicare. All Medicare Advantage plans have flexibility in how they structure their cost sharing for plan benefits, subject to the longstanding requirement that the average actuarial value of the plan's cost sharing for Medicare benefits may not exceed the average actuarial value of cost sharing in Original Medicare. Such flexibility can have the effect of generating cost sharing amounts for certain services that are higher than Original Medicare's in any Medicare Advantage plan, depending on the plan's cost sharing structure and the medical services needed by an individual enrollee.

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plan bid is above the benchmark, the enrollee must pay the difference in the form of a premium, referred to as the "basic beneficiary premium."

In addition, the Medicare law explicitly exempts PFFS plans from most of the quality assessment and reporting requirements that Medicare Advantage coordinated care plans must meet. Some plans assert that many of the requirements were designed with network-based plans in mind, making certain types of reporting (*e.g.*, those requiring medical record review) difficult for PFFS plans that do not have networks. However, other requirements such as beneficiary surveys and claims-based quality metrics may be possible for a non-network plan, when the statute permits.

Finally, there have been numerous complaints about the marketing practices of PFFS plans and enrollee issues with access to services. Some enrollees report that the plan's representatives did not adequately explain that providers may refuse to treat plan enrollees. Other enrollees report problems finding providers that will accept their plan's payment terms. As described in further detail below, CMS takes these concerns very seriously, and we are taking steps to ensure that beneficiaries are protected, and that there is better understanding of the PFFS product on the part of beneficiaries as well as providers.

CMS Oversight of PFFS Plans

CMS is aware that there are concerns about the marketing practices of some plans, as well as frequent misunderstandings on the part of both beneficiaries and providers about the nature of PFFS plans. We are particularly concerned about reports of marketing schemes designed to confuse, mislead or defraud beneficiaries, and are taking vigorous action to address violations. Possible CMS enforcement responses to marketing violations range from issuing a warning letter or corrective action plan, to suspension of enrollment, civil monetary penalties, or even

termination of the plan from the program. This year alone CMS has fined PFFS plans more than $400,000 in civil monetary penalties for failing to provide information to beneficiaries in a timely manner. Also to date, 98 plans have been put on a corrective action plan to fix identified problems and allow CMS to monitor progress.

CMS also takes steps to ensure that beneficiaries are protected. For example, it is long-standing policy that any beneficiary who believes he or she was enrolled in a plan without consent may contact the plan, 1-800-MEDICARE, or a CMS Regional Office for assistance in disenrolling from the plan and returning to Original Medicare if desired. CMS has caseworkers in all Regional Offices and in our Central Office available to assist beneficiaries in resolving such issues.

The CMS Medicare Marketing Guidelines include policies for MA plans designed to protect beneficiaries from inappropriate sales tactics. Medicare Advantage organizations must monitor the activities of employees and contractors engaged in marketing of plans to potential enrollees to ensure that their activities comply with applicable Medicare and other Federal healthcare laws. The guidelines explicitly address compensation of individuals involved in marketing, for example, stating that compensation must be in line with the industry standard for services provided and that compensation is to be withheld or withdrawn if an enrollee chooses to disenroll in an unreasonably short timeframe.

CMS requires that MA plans use only State-licensed marketing representatives, ensure that the identity and other information of a marketing representative is reported to a State when required,

cooperate with reasonable requests from a State that is investigating a marketing agent and ensure that terminations for cause are reported to the appropriate State agent, if the State has such a requirement. CMS also is working with State insurance department officials and the National Association of Insurance Commissioners (NAIC) to address problems with marketing. Part of this effort includes a Memorandum of Understanding (MOU) that allows States and CMS to share information more easily. For example, CMS can immediately share name specific agent/broker complaints with State Department's of Insurance. States are able to share with CMS their findings from Market Conduct reports. To date, 20 States and Puerto Rico have signed the MOU. The MOU has already facilitated action in some States to address complaints about marketing. CMS, NAIC and the States are working together to complete a full implementation of the MOU, which will provide a national structure for sharing information consistently.

In order to ensure that the marketing and outreach by PFFS plans is accurate and complies with all program requirements, CMS is in the process of clarifying current policy and developing additional PFFS marketing documents and other outreach materials. The list of actions is lengthy, but includes initiatives focused on:

- ***Marketing.*** Beginning no later than the November / December 2007 open enrollment period for the 2008 benefit year, CMS is requiring PFFS plans to include specific CMS-developed disclaimer language in all pre-enrollment materials as well as sales presentations explaining how PFFS plans work with respect to obtaining care from doctors and hospitals. Plans are encouraged to put this practice into place even sooner than the 2008 coordinated election period if possible. Certain plans also are currently

required under corrective action plans to call-back beneficiaries after an initial enrollment to confirm the intent to enroll.

- ***Training.*** For plan year 2008, CMS is requiring PFFS plans to provide documented training of marketing agents and brokers on Medicare Advantage policy as well as unique aspects of the PFFS product.
- ***Enrollment verification.*** Effective for the November / December 2007 open enrollment period for the 2008 benefit year, CMS is requiring PFFS plans to call all new applicants to confirm that applicants do, in fact, wish to enroll and that they understand the features of the plan.
- ***Provider payment policies.*** For the 2008 plan benefit year, CMS is strengthening requirements on transparency of provider payment rates, timeliness of payments to providers, and provider payment dispute processes.
- ***Provider education.*** For the 2008 plan benefit year, CMS is requiring plans to provide all enrollees with a uniform tear sheet explaining the PFFS option, which enrollees can use to discuss coverage with their treating providers.
- ***Medicare Handbook.*** For the November / December 2007 open enrollment period for the 2008 benefit year, CMS is adding clarifying language to the Medicare & You Handbook to ensure beneficiaries understand how the PFFS option works. As with all Medicare & You revisions, draft language is being vetted with beneficiary focus groups, policymakers and advocacy groups to help ensure effective messaging for people with Medicare.

Building upon lessons learned and information gathered during 2006, CMS is strengthening its oversight of Medicare Advantage plans across-the-board. CMS has improved its method for

identifying companies for compliance audits, making more efficient use of the resources available for ensuring compliance, and developing a closer relationship with State regulators. For example, CMS is working with a contractor to augment the internal agency resources available for compliance audits. Among other things, the contractor is conducting "secret shopping" of sales events across the country; such information enables CMS to learn firsthand what is happening in the sales marketplace and to identify organizations for compliance intervention that are not meeting CMS marketing and enrollment requirements. CMS is committed to taking whatever steps are necessary to ensure people with Medicare are not misled or harmed by Medicare Advantage plans or their agents.

Conclusion

Mr. Chairman, thank you again for this opportunity to testify regarding PFFS plans under Medicare Advantage. I would be happy to answer any of your questions.

Chairman STARK. You just mentioned that if a plan receives over the fee-for-service amount that they have got to distribute 75 percent of that spread to beneficiaries in extra benefits. What records do you have that indicate for each plan how they have distributed this 75 percent?

Ms. BLOCK. Well, let me say that some of those extra benefits are automatically received by the people who enroll in the plan because their reductions in premium or reductions in cost sharing that a beneficiary would receive automatically.

Chairman STARK. Yes, I understand that.

Ms. BLOCK. Others of those benefits are ones that we would hope that beneficiaries would never need to use.

Chairman STARK, but what I am asking you is that this money is supposed to be spent, is it not, the 75 percent, on the beneficiaries?

Ms. BLOCK. Yes, it is.

Chairman STARK. So, where it isn't in a premium reduction, it must be in other say eyeglasses, hearing aids, dental benefits. Do you keep a record or do the plans submit to you a record of what they spend?

Ms. BLOCK. Well, actually they don't but I can tell you that in terms of those benefits every survey that is done says——

Chairman STARK, but then the answer is that you don't know whether——

Ms. BLOCK [continuing]. There are the benefits that the beneficiaries want and therefore we can assume——

Chairman STARK [continuing]. They are spending it or not. Excuse me.

Ms. BLOCK [continuing]. That they use those benefits.

Chairman STARK. The answer is you don't know that they are spending——

Ms. BLOCK. The answer is we don't specifically record those extra—the utilization of those extra benefits.

Chairman STARK. So, you do not know? You do not know whether they are spending that money or not, do you?

Ms. BLOCK. We can make a very accurate presumption that beneficiaries are using the benefits that they want.

Chairman STARK. I asked you a simple question, you don't have any records of how the money is spent.

Mr. CAMP. I would like to hear her answer.

Chairman STARK. Yes, okay, but she said she does not know. She is not answering it.

Mr. CAMP. She is trying to answer the question if she was not continually interrupted.

Chairman STARK. Let me rephrase the question just so it is very simple, do you have records for each plan of how they spend the 75 percent on extra benefits?

Ms. BLOCK. No, I do not have records. However, I have customer satisfaction surveys that tell me that they easily access those benefits. I have every indication through surveys of what beneficiaries say they want, that they want benefits like eyeglasses, hearing aids, and other things that are typically provided. So, I think it is a safe assumption to make that when you give people benefits that they have asked for, they are likely to use them.

Chairman STARK, but you still do not know whether they do or not so I will stipulate that the answer is you do not know.

Ms. BLOCK. The answer is I do not record specifically the use plan by plan and beneficiary by beneficiary of every additional benefit.

Chairman STARK. Do the plans record that?

Ms. BLOCK. The plans would have to in order to do their bid estimates. They have to know how to cost their bid.

Chairman STARK. So, you believe that the plans would have actual information about how they take their 75 percent and spend it on beneficiaries other than through reduced premiums, is that correct?

Ms. BLOCK. If I were a plan actuary and I had to prepare a bid every year, I think I would need to know what my potential costs are. Otherwise, I cannot make my bid.

Chairman STARK. I guess what I am asking you is to your knowledge do you know that plans keep those records?

Ms. BLOCK. I can only assume that they do.

Chairman STARK, but you do not know?

Ms. BLOCK. I have not asked them since it would be irrelevant other than for bid purposes.

Chairman STARK, but it might be relevant to us who are responsible for the taxpayers' dollars. It may not be relevant to you.

Ms. BLOCK. Well, we could possibly ask Ms. Schmitt who was on the previous panel who represents a plan.

Chairman STARK. Okay. Let's assume for a minute that we are spending let's say give or take a few billion, $60 billion extra, in what are classified as overpayments or additional payments above the fee-for-service cost, let's say that we decided that we had to reduce that overpayment by $30 billion or $6 billion a year over five, how would you suggest that we reduce the payments to plans, in other words, we just cut it across the board or would you recommend to us ways that we might differentiate between plans and apportion these savings differently?

Ms. BLOCK. Well, I think if you are talking about the various products within the MA program, is that what we are talking about?

Chairman STARK. How do we know which ones—should we cut across the board or how could we be selective?

Ms. BLOCK. I think that we could look at some of the things that have already been mentioned and some of those things, as I have said in my statement and as other have said, Private Fee-for-Service plans are by statute exempted from, I think it be probably a wise idea to look at performance measures, quality of performance and certainly it might be a good idea to letting CMS review those plans' bids in the same way that we review other plans' bids. Those are some things that we might think about for starters. There are other things that we could certainly talk about in a more extensive discussion.

Chairman STARK. Do you review the plan bids now?

Ms. BLOCK. We do not review the Private Fee-for-Service plans. The statute does not allow us to.

Chairman STARK. Do you review the other, the MA plans?

Ms. BLOCK. Our actuaries review every MA plan, yes, the CMS actuaries review other plan bids.

Chairman STARK. Thank you. Mr. Camp?

Mr. CAMP. Well, thank you. It is statute that does not allow you to review the Private Fee-for-Service plans and the reason being the concern about what the government in connection with HMOs might do with regard to end of life decisions, is that an accurate statement?

Ms. BLOCK. Yes, I believe so.

Mr. CAMP. Are you familiar with—of the 75 percent that is put into additional benefits, I understand that MedPac has information on that, I do not know if you are aware of this but is it accurate that 65 percent of that additional money goes to lower co-pays, 15 percent goes to lower premiums, and 14 percent goes to additional benefits?

Ms. BLOCK. I think that is approximately correct.

Mr. CAMP. So, we do have some information in terms—in a macro sense where the additional dollars go for these plans. Ms. Block, yesterday, CMS announced a number of initiatives to address some of the marketing of uses by rogue sales agents and brokers. Can you discuss some of those new efforts?

Ms. BLOCK. Yes, we have announced a series of efforts. In our call letter for 2008, we have put in place some very specific requirements that we think will be significant in terms of curtailing some of what we consider to be the abusive practices of what we hope is a small minority of brokers and agents who are marketing the product. In addition to requiring much more extensive documentation of broker and agent training, we are requiring plans specifically to give every single person who is being sold a Private Fee-for-Service policy a tear sheet, which is essentially a disclaimer that tells them clearly the difference between a Private Fee-for-Service plan and original Medicare so that it is very, very clear to the potential purchaser that this is not original Medicare, that the provisions of the policy are different and access to providers is different.

We are also requiring them to provide a tear sheet for providers so that they will better understand the nature of the Private Fee-for-Service product. We are also requiring outbound call back to every beneficiary who enrolls or in some cases unfortunately, as I understand it, may not know that they have enrolled in a Private Fee-for-Service plan. Those beneficiaries will be called, they will be asked to verify that in fact that they signed that enrollment form, and they will be asked to clearly assert that they understand the nature of the product and that it meets their needs.

In addition to that we issued a Notice of Proposed Rule-making yesterday, which again streamlines our process by eliminating redundant procedures, by modifying the reporting requirements of fraud and misconduct so that plans will mandatorily have to report such action, and it will go through the normal regulatory process, but we believe it is a very good start in terms of strengthening our ability to manage this product. By the way, the regulations apply to MA plans and Medicare prescription drug plans across the board.

Mr. CAMP. Thank you. Can you tell me about the satisfaction of Medicare beneficiaries and if you have detail of various plans, I would be interested in that as well as Part D if you have it?

Ms. BLOCK. Well, in terms of MA, the satisfaction rate from our cap survey is 95 percent and that is really quite remarkable. In terms of Part D, we have not yet done our own survey, the cap survey that will actually assess satisfaction with Part D is being fielded right now, but other surveys talk about between 75 and 85 percent satisfaction rates.

Mr. CAMP. Do you have an opinion about the concept of requiring care management in Private Fee-for-Service?

Ms. BLOCK. I think care management is very important, and I think that there are many ways to accomplish care management even without contracting with network providers. I think that care management can be achieved by working directly with the patients, with the beneficiaries, in many ways that are positive. Given the incidence of people in Medicare with multiple chronic illnesses, I think this is a very important feature and one that I would like to see strengthened.

Mr. CAMP. All right, thank you very much. Thank you, Mr. Chairman.

Mr. POMEROY. Mr. Chairman?

Mr. CAMP. I yield back.

Mr. POMEROY. I did not want to impose upon the gentleman's time, I wanted him to get all his questions in but he led with a question, I did not understand it at all, the question on end of life care? I am wondering if the gentleman would allow Mr. Camp extra time to inform those of us new to the Committee what that is all about.

Mr. CAMP. There is a lot in the public record about that and the background of the legislative history as to why CMS is not allowed to ask these questions. That was in statute really with a concern about what HMOs might do in terms of managing end of life decisions in that the government would be a part of that decision and so there was a wall put up legislatively, statutorily, between those two. That is the only question I was asking.

Chairman STARK. Mr. Doggett?

Mr. DOGGETT. Thank you very much. Ms. Block, exploring first some other areas, I had some concerns expressed by local health care providers, specifically physicians, that they do not—they are not able to access up-to-date information about which specific MA program a patient might have or whether they have traditional Medicare, and they may bill thinking it is traditional Medicare because they cannot access current information on the database. Is that a problem of which you are aware?

Ms. BLOCK. That is a problem, sir, that I have heard about and it is a problem that I believe has been fixed. It has to do with how the patient's enrollment is recorded on the common database, on the common working file.

Mr. DOGGETT. Physicians that have discussed it with me have been experiencing that problem very recently. I would just ask you to check and see what might be done to address that concern. Then another area we have not discussed yet is the area of cost contracts. I understand that while they are not as efficient as tradi-

tional Medicare, they are not as expensive as the MA plans and are beneficial in some rural communities. What is your assessment of the way cost contracts have been working?

Ms. BLOCK. Well, as you know, there is a statutory provision that would sunset cost contracts under certain circumstances. As of this point in time, there are some cost contracts still functioning and where they are functioning efficiently and so long as the statute permits them to continue to exist, I have no problem with their being there.

Mr. DOGGETT. Well, I suppose since you have some oversight of the quality and efficiency of health care you would not just be waiting to see when the statute runs out but might want to offer some opinion as to whether such contracts should continue in the future, is not that the case?

Ms. BLOCK. Well, that is something that we could certainly discuss but frankly cost contracts have some of the same limitations as some of the other things we are discussing in terms of how they function, what kind of coordinated care they do or do not provide, what they report to CMS in terms of their quality and so on so there are similar issues.

Mr. DOGGETT. There are certainly similar issues, my question is then whether CMS is doing any evaluation of the desirability of continuing the cost contract approach and how well it is operating?

Ms. BLOCK. Well, it is not something that we have particularly focused on at the moment but is certainly something we can look into in the future.

Mr. DOGGETT. The local paper from Austin, one of the communities that I serve, had some comment this morning about I guess the press availability that you and Ms. Norwalk had yesterday, noting that while we were—I would reflect that while we were told when this bill was passed that these private plans would be cheaper and better, that they certainly have not been cheaper, it is about $120 more per beneficiary. Let me just quote from this, this was actually yesterday, "By law, the Private Fee-for-Service plans must provide an average of $61 worth of extra benefits per enrollee but Norwalk and Block said Medicare cannot account for the remaining $79 per beneficiary paid to the plans. They acknowledge that much of the money goes into management and profit for the plans." Is that accurate that you do not know where the $79 per beneficiary goes other than for management and profit of the plans?

Ms. BLOCK. Well, I think what is being alluded to, and again it comes back to the fact that unlike other MA plans, we do not review the bids of Private Fee-for-Service plans so we do not have the same sense nor do we have the same authority to negotiate those bids that we do with other MA plans.

Mr. DOGGETT. So, since you do not know, it is certainly possible that they may be getting $79 per beneficiary in profit and management costs?

Ms. BLOCK. Well, again, this is a competitive market and I really believe that in order——

Mr. DOGGETT. It does not seem like a competitive market.

Ms. BLOCK [continuing]. To succeed in a competitive market, you have to offer people something.

Mr. DOGGETT. As far as that competition, I believe you told Mr. Camp that you had acted on the eve of this hearing to address abusive practices of brokers and agents, I trust you would not have acted had you not determined that there were significant abusive practices that needed to be stopped?

Ms. BLOCK. We acted before the eve of this hearing. We issued our call letter for 2008 some time before this hearing. As we have become aware of the abusive practices, we have been very concerned about them and are still very concerned about them and have and will continue to take very strong action to make those abusive actions stop.

Mr. DOGGETT. What report or evaluation do you have to indicate how extensive these abusive practices have been?

Ms. BLOCK. Well, we have the complaints that we receive. We have also, and unfortunately it was not mentioned by the gentleman from Wisconsin who was on the previous panel, but we have put in place after working very closely with the NAIC a policy of signing of memoranda of understanding with the States, 20 States and Puerto Rico have signed that MOU so far.

Mr. DOGGETT. Actually, I believe one of the witness referred to the Memorandum of Understanding but what I am seeking with my time expiring is to know if there is a report, a memo, something from CMS that details the extent of abusive practices that produced the action that you have described?

Ms. BLOCK. We track complaints, we track through interaction with the States, what the States are hearing, we talk extensively to beneficiaries, to beneficiary advocates, we have multiple sources for learning about problems and clearly we have learned about problems in the marketing of the Private Fee-for-Service products.

Mr. DOGGETT. Which individual entity, office, department or section of CMS recommended that this action to discourage abusive practices needed to be taken by CMS?

Ms. BLOCK. Well, this was a CMS agency decision. It was not a single——

Mr. DOGGETT. Who started——

Ms. BLOCK. Excuse me?

Mr. DOGGETT. Where did it start, where did emanate from?

Ms. BLOCK. I am not sure I understand your question.

Mr. DOGGETT. Well, I suppose that there was some individual that said this problem is sufficient that we need to move forward with this new action and how did that start?

Ms. BLOCK. Well, the division, the center that I head, the Center for Beneficiary Choices, is responsible for administering both the MA and the Medicare prescription drug program. It is my office that receives the complaints, that deals with the complaints, working closely with the CMS regional offices, by the way, because they have an active role in this. It was the consensus within CMS that we needed to take action and we have done so.

Mr. DOGGETT. So, you started this, your office?

Ms. BLOCK. Well, I personally as the director of that office, along with many other people in CMS, certainly had input into that decision.

Mr. DOGGETT. You have no problem then in providing to the Committee all of the intra-office, inter-agency as well memoranda that gave rise to this recommendation?

Ms. BLOCK. I am not sure what recommendation you are referring to, sir. We took multiple action that I have already mentioned. If you are talking specifically about the compliance rule or are you talking about the call letter for 2008, I am not sure what action specifically we are discussing?

Mr. DOGGETT. Both of those, all of the documents that reflected the problem that you saw needed to be attended to by both of those actions.

Ms. BLOCK. I really would have to consult with my general counsel about providing inter-office memos.

Mr. DOGGETT. Why don't you do that and we will try and get you a specific request on it. Thank you.

Chairman STARK. Mr. Becerra, would you like to inquire?

Mr. BECERRA. Thank you, Mr. Chairman. Ms. Block, thank you for being here with us this afternoon and thank you for your patience as well. The California Medical Association (CMA) has apparently contacted CMA on several occasions and asked that with regard to the Private Fee-for-Service program that CMS require that these Private Fee-for-Service plans offer on a website or in some consolidated fashion information on their payment schedules for physicians because physicians are complaining left and right, up and down that they have no way of knowing what the payment schedules are like. They are concerned that CMS has ignored their solicitations in that regard. I am wondering if you could tell me whether or not CMS has taken on this issue that was raised by California Medical Association?

Ms. BLOCK. I am happy to say that contrary to ignoring the issue, what we have just done, and I think it is just a beginning, we have posted on our own website information on accessing the websites of each of the plans that offers this product and specifically the place on those websites where providers can in fact access that information.

Mr. BECERRA. So, you are saying to me that there is a single website for these Private Fee-for-Service plans that offers the terms and conditions readily viewable for physicians to see on these Private Fee-for-Service plans?

Ms. BLOCK. There is now a single website, a CMS website, that provides links to every single plan.

Mr. BECERRA. Okay, that is fine that CMS has a website. I do not think the physicians are asking CMS to have a website, they are asking for these Private Fee-for-Service plans to have a website.

Ms. BLOCK. Yes, but since there are several hundred of these plans, what our website does is give you a link to each plan's website so that a physician can go from our website to that plan's website and access all of the information.

Mr. BECERRA, but, Ms. Block, I do not think that is the California Medical Association, the physicians, the thousands of physicians in California who belong to the California Medical Association, I do not think they are concerned or interested in having to

access your website to find out the payment terms and conditions of a Private Fee-for-Service plan.

Ms. BLOCK. What I am telling you is that every Private Fee-for-Service plan, sir, must have on their website the information available. What we are doing is——

Mr. BECERRA. If I could ask you, Ms. Block, as of when have those plans been required to post that information?

Ms. BLOCK. Absolutely.

Mr. BECERRA. As of when?

Ms. BLOCK. They are required to post that information and our website will take the provider from our website to the plan's website.

Mr. BECERRA. As of when have those plans been required to post that information on a website?

Ms. BLOCK. It is my understanding that they always had to make that information available.

Mr. BECERRA. Always, since the beginning of the program?

Ms. BLOCK. That is my understanding.

Mr. BECERRA. Okay, and can you provide me with the statute or regulation that requires them to post that information, the terms and conditions on their website?

Ms. BLOCK. Yes, the statute——

Mr. BECERRA. You do not need to do it right now, you can just provide it later on. You say that they are required, I will take you at your word if you can just provide me with the regulation or the statute that requires them to post it.

Ms. BLOCK. I just want to make it clear what the statute says is the information must be available and having it available on a website is a satisfactory way of providing the information.

Mr. BECERRA. So, if you have a website that has billions of bits of information and in one little section you might have information about one reimbursement for service and in another section of the website you might have hidden some information about how you get paid for another service, it could take a physician scores of hours to try to make sense of the terms and conditions under which that physician might be operating under that Private Fee-for-Service plan. So, let me ask it more specifically, to your understanding, is there anything under the law that requires these Private Fee-for-Service plans to make available in a single readable document information about terms and conditions for reimbursement that these physicians would have to abide by if they were to work with this Private Fee-for-Service plan?

Ms. BLOCK. Let me try to expound——

Mr. BECERRA. No, no, I asked a pretty specific question. If you do not know, that is fine, you can tell me that.

Ms. BLOCK. No, no, the answer is very simple, a provider does not have to accept the terms and conditions of a Private Fee-for-Service plan.

Mr. BECERRA. That is fine, that is fine. I will accept that.

Ms. BLOCK. So, a provider who does not want to do that——

Mr. BECERRA. Ms. Block? Ms. Block?

Ms. BLOCK [continuing]. Does not have to.

Mr. BECERRA. Ms. Block, I am asking you specifically if you can guide me on what the law requires you to require of the plans, I

do not need for you to explain to me all sorts of other things. That is fine if I were asking you questions about that but right now I am trying to figure out why thousands of physicians in California are asking for the elimination of the Private Fee-for-Service plans because they say with all the fraud, with the disruption, that they would prefer not to see—and these are physicians that are treating a lot of Medicare patients, and so what I am trying to get from you is some guidance as to why they say, and I will quote, "CMA, the California Medical Association, has repeatedly asked CMS to require Private Fee-for-Service plans to post their payment rules on a single website where physicians can readily obtain this information. Unfortunately, patients who see deemed physicians," and we will not get into the categorization of deemed physicians, "must pay higher copayments." They go on to say that you have—CMS has ignored their request for that requirement that that information be posted on a website. So, let's do this, my time has expired.

Ms. BLOCK. I would love to have a dialog with you about this. Why don't we try to do that?

Mr. BECERRA. Excellent and then maybe you can provide me with the information about the rules and regulations when we follow up. I appreciate that very much. Mr. Chairman, thank you for the time.

Chairman STARK. Thank you. Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. I would. Thank you, Mr. Chairman. I am a little perplexed on the State of regulation of plans. The insurance commissioner said he could regulate agents but not company activity in this Private Fee-for-Service market, is that correct?

Ms. BLOCK. That is correct.

Mr. POMEROY. Who regulates the companies?

Ms. BLOCK. CMS does.

Mr. POMEROY. What kind of staffing additions did you have to undertake this new insurance regulatory responsibility upon the passage of this portion of the Medicare Modernization Act?

Ms. BLOCK. Well, depending on what we are talking about, we have contracted with the so-called Medics.

Mr. POMEROY. Have you outsourced regulation?

Ms. BLOCK. We have outsourced to the Medics, some of this.

Mr. POMEROY. What have you outsourced to Medics?

Ms. BLOCK. The Medics are contractors who have investigative authority in terms of program integrity, and we have outsourced——

Mr. POMEROY. Does Medics evaluate caliber of coverages proposed to be sold by companies?

Ms. BLOCK. No, no.

Mr. POMEROY. Who regulates that? Who regulates that?

Ms. BLOCK. We regulate——

Mr. POMEROY. I do not care about Medics at this moment, who regulates that?

Ms. BLOCK. There is no——

Mr. POMEROY. There is no regulation of plan content, okay.

Ms. BLOCK. There is very careful review of plan content by my staff, sir.

Mr. POMEROY. Okay, now what kind of staffing—so every plan sold by every company in Private Fee-for-Service is very closely reviewed by your staff. How many staff did you get for this function?

Ms. BLOCK. Let's separate MA from Private Fee-for-Service. Our review of Private Fee-for-Service, as we have kept saying, is different than our review of other MA products.

Mr. POMEROY. What really bugs us is when you blow our 5 minutes with not answering the questions.

Ms. BLOCK. I am trying to answer your question.

Mr. POMEROY. I am going to try and make my questions so incredibly clear that you cannot miss it.

Ms. BLOCK. In terms of Private Fee-for-Service,——

Mr. POMEROY. I asked you how many you hired for this function.

Ms. BLOCK [continuing]. We review benefits only in terms of making sure that the cost-sharing is not discriminatory.

Mr. POMEROY. So, the only review—thank you, I appreciated getting right to the question. The only review you do of private plans is——

Ms. BLOCK. Private Fee-for-Service plans.

Mr. POMEROY [continuing]. To look at the pricing to make sure the pricing is not discriminatory, is that what you answered?

Ms. BLOCK. That the cost-sharing is not discriminatory.

Mr. POMEROY. The cost-sharing is not discriminatory. Do you review whether or not the benefits in the plan change on a yearly basis?

Ms. BLOCK. We review the benefits each year.

Mr. POMEROY. Can they be changed each year?

Ms. BLOCK. Yes, they can. As with any other MA plan, they can be changed.

Mr. POMEROY, but quite differently from the——

Ms. BLOCK. By the way, like as with every other commercial insurance product.

Mr. POMEROY. Well, there is a guaranteed right of renewability for some coverages or an option of other coverages in the event that the existing coverage has changed and that is a protection commonly added at the State level for the senior market. Now, how about level commissions, do you address the commission structure that these companies reimburse their agents?

Ms. BLOCK. Only in terms of the fact that the commission structure has to be reasonable in terms of the complexity of the product being sold.

Mr. POMEROY. Is a first year commission allowed to be sold that is at a higher rate than a renewal commission?

Ms. BLOCK. We do not specifically regulate commissions.

Mr. POMEROY. You do not. Can the private insurance commissioners—the insurance commissioners, they cannot regulate commissions because that is an insurance company deal so we do not have regulation of commission structures?

Ms. BLOCK. We do not currently have regulations of commission structures.

Mr. POMEROY. Do you review advertising and marketing?

Ms. BLOCK. Yes, we do.

Mr. POMEROY. So, every policy marketed by Private Fee-for-Service writers is filed with your staff?

Ms. BLOCK. It is filed with the regional office in which it operates.

Mr. POMEROY. Is that an outsourced activity or is that an activity by your staff?

Ms. BLOCK. It is not my particular staff, it is CMS staff. It is done by the CMS regional offices.

Mr. POMEROY. How many personnel were added at the regional offices for this function?

Ms. BLOCK. I do not have an exact number.

Mr. POMEROY. Well, do you have an estimate?

Ms. BLOCK. No, I really——

Mr. POMEROY. Was anyone hired, was anyone additionally hired for this function?

Ms. BLOCK. Yes, additional people were hired in the regional office, but I do not have an exact number.

Mr. POMEROY. Were hundreds hired? I would like that number. Would you please submit that number following the hearing?

Ms. BLOCK. Certainly.

Mr. POMEROY. Thank you. There is another matter and that is you talked about how great this is for the rural areas, first of all, by the way, did it ever occur to you that it light of the elaborate protections presently in place on the senior market, including the MediGap market by the States, that you might have worked with State commissioners to embrace some of these protections?

Ms. BLOCK. We are working with State commissioners and, as I explained, we have a Memorandum of Understanding process in place. We are eager to work with State commissioners and will continue to do that.

Mr. POMEROY. Well, I believe that if you had been working with State commissioners, you would have some of these fundamental protections in place as well as working relationships so these policies are reviewed by staff sufficient to accomplish that task. My belief is you would have working relationships with State insurance departments charged with consumer protection rather than outsourcing to private vendors. My belief is you would have working relationships with State insurance departments charged with consumer protection rather than outsourcing to private vendors. My belief is you would have a very different situation than what you have got today.

Now, the issue of reimbursement. In a rural area, you have critical access hospitals that are reimbursed at a 100-percent rate of cost. Are you doing any plan oversight for Private Fee-for-Service to make certain these hospitals are recovering what they need as a judgment of the Medicare program to stay open?

Ms. BLOCK. We are doing exactly what we need to do to ensure that payment is made in accordance with the provisions of the statute.

Mr. POMEROY. What are those provisions?

Ms. BLOCK. The provisions of the statute are that a Private Fee-for-Service plan may not pay less in reimbursement than would be paid under original Medicare.

Mr. POMEROY. What if they pay at the interim rate and settle up at the end of the year, your staff will help determine that the settlement at the end of the year is at Medicare rate?

Ms. BLOCK. I do not believe we have been asked to do that.

Mr. POMEROY. Really? Since I have six different hospitals in North Dakota that I inquired, it was a small matter, I do not have a large staff for this matter, and I called and none of them are getting the Medicare rate. Additionally, how about prompt payment, do you oversee that?

Ms. BLOCK. All of the provisions that are in place for resolving disputes apply.

Mr. POMEROY. What does that mean?

Ms. BLOCK. It means that all of the provisions that would be in place under traditional Medicare applies to this product as well.

Mr. POMEROY. Do you have a call center where my hospital that has not been paid since April 2006 on a claim can call and report the insurance company?

Ms. BLOCK. They could call my office, sir. I have not to my knowledge received such calls but if you have examples or there are hospitals in that situation, by all means have them call me.

Mr. POMEROY. I have many examples, one hospital called one insurance company "a royal pain," another hospital called another company "a billing nightmare." This other one is waiting until April 2006. So, I am pleased to hear that your office responds to queries from hospitals that have not been promptly paid and you are telling me that virtually you have not known that hospitals are out there not receiving prompt payment. This is news to you that some have not received prompt payment from a Private Fee-for-Service provider, is that what you are telling me—from a Private Fee-for-Service insurer?

Ms. BLOCK. I am telling you that I personally have not been made aware of such situations. If someone wishes to make me aware of them, I would appreciate it.

Mr. POMEROY. All right, thank you. I yield back, Mr. Chairman.

Chairman STARK. Thank you. Ms. Block, I just wanted to go back. You kindly in your testimony provided us with a chart that suggested that 68 percent of the plans charge no more than Medicare for hospitalization. I cannot find the exact testimony here but I think that is, if my memory serves me, close enough. Does that in fact imply that 32 percent of the plans charge more than Medicare for hospitalization?

Ms. BLOCK. I am sorry, I am trying to find the chart that you are referring to.

Chairman STARK. It is on page seven of your testimony.

Ms. BLOCK. Yes, I have it.

Chairman STARK. You show the attributes and you show the benefit structure and the percent of beneficiaries enrolled in a plan of this type. Then you say the benefit structure is $1,000 or less for a 90 day hospital stay. Now, when you say that 68 percent of the beneficiaries that are enrolled in a plan of that type, does that mean that 32 percent of the beneficiaries are enrolled in a plan that has more than $1,000 for a 90 day hospital stay?

Ms. BLOCK. I would presume so, yes.

Chairman STARK. Okay.

Ms. BLOCK. That would be what the arithmetic would imply.

Chairman STARK. What you do not mention is that there are plans that we understand that charge co-pays for home health or durable medical equipment or skilled nursing facilities, which Medicare does not charge for. Do you have records on those benefits for which people are charged more than they would pay under Medicare fee-for-service?

Ms. BLOCK. Private Fee-for-Service, like MA plans, have to provide comparable actuarial value for Medicare part A and B benefits through original Medicare.

Chairman STARK. I think I understand that.

Ms. BLOCK. However, they can arrange those copayments in different ways.

Chairman STARK. So, they can in fact charge much more if they wanted to to certain beneficiaries for certain procedures?

Ms. BLOCK. They can charge more for certain procedures, less for others.

Chairman STARK. Could that become discriminatory, do you suppose?

Ms. BLOCK. I suppose it could and that is why we review benefits specifically with that in mind.

Chairman STARK. You do review them then?

Ms. BLOCK. Specifically in terms of——

Chairman STARK. So, you review all the co-pays?

Ms. BLOCK. In order to determine whether benefits are in fact or have the potential of being discriminatory.

Chairman STARK. I wanted to go back just for a minute because, as you say, you are in charge of part B and MA, and we talked about the 75 percent and since we talked about that, I am advised that its current year, and I imagine this of 2006, the 75 percent would amount to $8.3 billion that is the 75 percent that should be spent on beneficiaries, you have no record of that $8.3 billion but over 5 years at a very minimum because I think, as many people have indicated, these plans are growing rapidly, are they not? Many people are signing up. So, at a bare minimum over the next 5 years, there is going to be $41 billion to be spent under this 75 percent that is supposed to be spent for extra benefits. Do you not think that it would be a good idea for us to have some idea of where this more than $8 billion a year of taxpayer money is going and to review and audit to see whether these plans are really spending it?

Ms. BLOCK. Are we talking specifically about Private Fee-for-Service plans?

Chairman STARK. I am just talking about the fact that there is $8.3 billion that is supposed to be spent in the 75 percent extra and you do not know whether it is being spent or how it is being spent. So, basically we are handing out more than $8 billion a year to these plans and you do not know whether they are just putting it in their pocket or whether they are spending it. Don't you think it would be a good idea for us to regulate that?

Ms. BLOCK. I think I need clarification, sir, are we talking about all MA plans or are we talking specifically about Private Fee-for-Service?

Chairman STARK. Yes, we are talking about all plans, all MA plans.

Ms. BLOCK. Well, for all MA plans we do have information. Our actuaries view——

Chairman STARK. No, no, "actuaries-schmactuaries," you do not have records, as you just testified a few moments ago, on how the 75 percent is spent or if it is spent, do you?

Ms. BLOCK. I think we do and I think——

Chairman STARK. Oh, you think you do now?

Ms. BLOCK. Yes, I think we have provided you with information on the Healthcare Effectiveness Data Information Set measures that we collect,——

Chairman STARK. I am not talking——

Ms. BLOCK [continuing.] Other resources——

Chairman STARK. Ma'am, can I go back a minute?

Ms. BLOCK. —that have an actuarial review——

Chairman STARK. Stop, stop, let me just try this very simply. I am not talking about polling or satisfaction, I am talking about dollars and the law as I understand it, correct me if I am wrong, requires that this 75 percent we are talking about be spent on additional benefits, as you said some of it may be in lower premiums but not all of it. So, I am saying that in the parlance that we are using for our 5 year budget that we are looking for some savings, there are $41 billion that you are unable to identify, you cannot tell me how it is being spent or if indeed it is being spent as the law requires on beneficiaries. You presume it is because nobody is complaining but I am sorry I cannot presume that everybody is filing their income taxes just because they are not complaining. What I want to know is is it being spent, can we verify that? If we were talking about a few thousand bucks a year, I would not be—but this $8 billion a year, ma'am, and you do not know where it is going. You are only presuming it is being spent. Now, do you not think it would be a good idea that we had accurate records of how it was being spent and that we audit that?

Ms. BLOCK. I think I have answered your question. I think that we have a very good indication of how that money is being spent. I think we do take steps to understand how it is being spent. I think that from year to year in the bid process, that is in fact reviewed. I think that if the Committee and the Congress decides that it wants to monitor in a different way, then you will pass legislation to do that.

Mr. CAMP. If the gentleman would yield?

Chairman STARK. Sure.

Mr. CAMP. I think what the Chairman might be asking is while CMS does not have individual records, is it true that you are able from other data to composite and determine whether for example co-pays are lower or other such information from the data that you have available?

Ms. BLOCK. Well, for one thing we do do financial audits of health plans so plans are audited. There are provisions in place to do regular and periodic auditing of the finances of plans. Certainly we have information, again based on our review of benefit packages, on our review of bids, that gives us a clear indication of how plans are spending the Government's money.

Mr. CAMP. Yes, but I think it is this individual data that the Committee is interested in that has been referred to several times that we do not have available, but I understand what you are trying to say is that you are able to surmise from the research and investigation that you do. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Well, I appreciate your assistance. I would hope, Ms. Block, dinner time has come and gone, you have been very kind and I apologize for keeping you here so late, perhaps you could review and your staff, who are studiously taking notes there, could review and give us an indication—oh, Mr. Becerra wanted another question—but perhaps you could give me an outline of how we might ascertain exactly what is being—how this $8.3 is being spent and whether the information actually exists on a plan by plan basis so that we would have some idea of what this extra money over above fee-for-service is actually going toward.

I appreciate that you feel that the beneficiaries are satisfied, but I want to know maybe they are buying them all medical marijuana, that would satisfy a lot of Californians, but could we get some more detail as to which plans are providing which benefits? That would help us as we try and decide how we might adjust the payments, you could also help us in that regard, to save money to keep Medicare alive. That is what we are trying to do, your help would be appreciated. Mr. Becerra, do you want to have the last word?

Mr. BECERRA. I do not know if it is the last word, Mr. Chairman, but I do appreciate it and I will try to rather than go into an elaborate question, I will see if I can just keep straight to the point to give Ms. Block a chance to try to respond just specifically and succinctly to that. Going back again to the whole issue that the doctors from California have raised, we will follow up—Ms. Block, we will follow up in that discussion. Again, I am going to try to find out if there is anything that CMS has done to require that Private Fee-for-Service plans are offering information about the terms and conditions that they offer to physicians for payment are within a specific website for that Private Fee-for-Service plan, and we will follow up.

Secondly, a quick question, Mr. Pomeroy asked a line of questions with regard to your oversight responsibilities and your ability to make sure that these MA plans and specifically Private Fee-for-Service plans are following the rules because we have heard of many, many cases of abuse and so forth. Do you believe you have the resources and staff necessary to do the sufficient oversight you must do to make sure that the plans are abiding by the rules and regulations currently in place for MA?

Ms. BLOCK. I have an exceedingly hardworking staff, and I can assure you that they are doing everything that they need to do and will continue to do that to make sure that everybody is acting in accordance with the rules.

Mr. BECERRA. Does that exceedingly hardworking staff have all the resources it needs to perform the compliance work, the oversight work, that the taxpayers and Medicare beneficiaries except CMS to perform?

Ms. BLOCK. My staff is doing everything that it is required to do.

Mr. BECERRA. Okay, that is not my question, and I think all of us understand that, we all have staff who work very, very hard and do everything they can. I am asking you as the director of CMS if you have all the resources and staff that you need to provide the taxpayers and Medicare beneficiaries with the oversight that is required by law on these plans as they go out and provide services to our public?

Ms. BLOCK. That is a really difficult question to ask because I do not think that any of us would given the opportunity not like to have more and more resources.

Mr. BECERRA. Here is your opportunity.

Ms. BLOCK. I think we are working within the resources allocated to us to do everything that we are required to do.

Mr. BECERRA. I appreciate your dilemma of having to try to work within the budget that you are provided. Let me ask the question a different way. With the budget that you are given for the staff and tools that you have or need, are you able to perform responsibly the work of oversight that you are charged with at CMS to protect not just the taxpayer dollars but the Medicare beneficiaries services that CMS oversees?

Ms. BLOCK. Well, with the caveat that none of us are perfect, and I would not want to suggest for a moment that we are perfect either, but I think that we are doing a really good job.

Mr. BECERRA. Okay, so there is no reason that later on in this year you would be coming up here to explain to us why you need more resources or you needed more staff to do oversight because of abuses that are alleged against certain Private Fee-for-Service or other MA plans?

Ms. BLOCK. That would not be my decision.

Mr. BECERRA. Well, you are saying that are able to do with your exceedingly hardworking staff the work that you are supposed to do for the public and the taxpayers and Medicare beneficiaries, I am assuming that means that you have what you need, otherwise you should tell us because we would love to be able to know that we are providing you with the resources you need to do the oversight so we do not waste taxpayer dollars or allow Medicare beneficiaries to go without when they are paying for those services?

Ms. BLOCK. I think I have answered your question to the best of my ability given my position in the agency.

Mr. BECERRA. Okay, if that is the best of your ability, than that we will accept. Final question, Mr. Chairman, the marketing abuses that have been raised, the way that some of these plans have gone after certain types of Medicare beneficiaries to enroll in their plans, you highlight that CMS will be requiring or has required specific, let me quote from your testimony, "specific CMS-developed disclaimer language on all pre-enrollment materials as well as sales presentations explaining how Private Fee-for-Service plans work with respect to obtaining care from doctors and hospitals." Do you have that disclaimer language now written?

Ms. BLOCK. Yes, we do.

Mr. BECERRA. Would you be able to provide that for the Committee so we can see what the disclaimer language is?

Ms. BLOCK. Yes, we could do that.

Mr. BECERRA. With regard then to the marketing abuse issue, one of the problems that oftentimes we find is that for what we call the dual-eligible Medicare beneficiaries, those who are eligible for Medicare services and Medicaid services, so they are supplemented because they are more modest income individuals, they really do not need to apply to these Private Fee-for-Service plans for coverage since they are receiving the Medicaid benefits on top of the Medicare benefits to make sure they have what they need. Yet, some of these Private Fee-for-Service plans are actually soliciting that these dual-eligible Medicare beneficiaries apply to their plans, which is not only an abuse but it is an over-use of taxpayer dollars. I am wondering if you can tell me what CMS is doing to try to make sure that that type of abuse of the dual-eligible population is not occurring?

Ms. BLOCK. Well, I think again it is a market-based program and dual-eligibles, like everyone else, have the option of choosing how they wish to obtain services and where they wish to be enrolled. I do not know that I have any authority anywhere to preclude a plan being offered or marketed to dual-eligibles.

Mr. BECERRA. So, you are saying that it is your belief that CMS can do nothing about the marketing practices of those plans that are going after individuals who are low income and because they are low income are given a taxpayer subsidy under the Medicaid program to help supplement their Medicare coverage and that we have nothing we can do under CMS?

Ms. BLOCK. If the product is being marketed fairly and beneficiaries are getting complete and accurate information, then the plan is meeting all of the requirements.

Mr. BECERRA. I want to stop because I do not want to use up the time but let me try to understand, someone who is dual-eligible has access to a physician because he or she not only has Medicare but can turn to Medicaid, in California we call it MediCal, for provision of his or her health care services. The attraction of these Private Fee-for-Service plans is that they profess to offer services additional to those that traditional Medicare might offer someone who would have to then supplement through some other insurance, MediGap or some other form of payment, the coverage for services that are not included within traditional Medicare.

For the dual-eligible, who has Medicare and Medicaid, that is not an issue. When these Private Fee-for-Service plans that we have determined are overcharging by one-fifth or are receiving payment beyond what traditional Medicare providers are receiving, by one-fifth so they are receiving 20 percent more dollars on average, some far more than that, go out and try to recruit, to market to these dual-eligible individuals and recruit them to be part of their plan, they are in essence feeding at the trough because the taxpayer has already said to these modest income individuals, you are going to get not just Medicare but Medicaid and so there are taxpayer dollars from two sources providing the health care for that modest income individual, and you have a Private Fee-for-Service plan which is already getting on average at least 20 percent more from taxpayers through Medicare now going after people who have subsidized care through Medicare or Medicaid and having them enroll in their program, it seems like a dual abuse of the system and you

are saying that CMS cannot do anything about it because it is a market-based program?

Ms. BLOCK. I have no authority to preclude someone from marketing to dual-eligibles?

Mr. BECERRA. Would you like that authority?

Ms. BLOCK. I would have to look into the specifics of what you are talking about.

Mr. BECERRA. I see, okay. Well, I appreciate your testimony. Mr. Chairman, thank you for the time.

Chairman STARK. I thank everybody for their patience and the hour is late, the hearing is adjourned. I will reconvene just long enough to say that the record will remain open for 2 weeks for Members to submit written questions to witnesses.

[Whereupon, at 6:30 p.m., the hearing was adjourned.]

[Questions submitted by the Members to the witnesses follow:]

Questions from Mr. Stark to Mr. Dilweg

Question: How many new MA policies have been sold in Wisconsin during the time period in which you received the 400 Medicare complaints?

Answer: The 400 complaints referenced in my testimony were for the period January 1, 2006 through April of 2007. My testimony indicated that according to the CMS website there are 92 MA Plans available in Wisconsin for 2007, 50 of which are MA Private Fee for Service plans. In Wisconsin in 2007, there are 130,645 enrollees in MA plans. In 2006, according to the Kaiser Family Foundation, there were 128,494 persons enrolled in MA plans in Wisconsin, 83,311 of which were in a Private-Fee-for-Service Plan.

It is from this increasing population in MA products did we receive the complaints referenced in my testimony. As you can see in our response to your next question, the 400 complaints are very high for a particular product line when compared to health insurance products in general. In 2005 there were approximately 3.2 million people covered by health insurance products in Wisconsin. That year we received 3,500 complaints concerning accident and health insurance business.

Question: How does the complaint rate for Medicare products compare with other health insurance product complaints in the State?

Answer: It is difficult to compare complaint rates between Medicare-related products and other health products due to the lack of jurisdiction over enrollment and claims complaints for MA and Medicare Part D products. These complaints are forwarded to CMS for handling and are counted as inquiries or referrals in our records. Of the complaints that we did handle, there was a 71% increase in complaints about Medicare-related products between 2005 and 2006. There were 277 complaints in 2005 and 477 in 2006. In comparison there was about an 18% increase in individual health insurance complaints between 2005 and 2006. There were 376 complaints in 2005 and 440 complaints in 2006.

Another way to look at the complaints rate between MA and other health insurance is by population covered. In 2007, 130,645 people are covered by MA. This block of business, generated 400 complaints or.3% of the population in the block filed complaints. In 2005, approximately 3.2 million Wisconsinites were covered under other health insurance. We received 3,500 health insurance complaints in 2005, not counting Medicare complaints, or.1% of that population filed complaints. This shows that, on a comparative basis, more MA insureds filed complaints by 3 times the rate than other health insurance.

Finally, to put the complaint numbers in a sharper perspective, the 400 complaints are formal written and filed complaints. This office takes many MA complaints by phone and, because of the Federal preemptions, these phone calls are referred to CMS.

Thank you for the opportunity to address the Subcommittee and I look forward to working with you.

Questions from Mr. Stark to Ms. Schmitt

Question: What is the Medical loss ratio for your Private Fee-For-Service plan? How does that compare with the loss ratio for other Medicare and non-Medicare products you sell? Please also provide information on admin-

istrative expenses and retained earnings for Private Fee-For-Service, other MA products and non-Medicare products.

Answer: In 2006, Blue Cross Blue Shield of Michigan (BCBSM) observed a medical loss ratio of 96.8 percent ($223.0 million in benefit expenses compared to $230.4 million of revenue). Administrative expenses incurred for 2006 were $19.1 million (8.3 percent of revenue) leaving BCBSM with a loss of $11.7 million (5.1 percent of revenue).

The only other MA product BCBSM has is an HMO through its subsidiary, Blue Care Network of Michigan (BCN). BCN's observed medical loss ratio in 2006 was 96.7 percent. Due to the fact that enrollment was limited in this plan (less than 5,000 beneficiaries) the administrative expenses were 33 percent of revenue leaving BCN with a *loss* of $10.9 million.

BCBSM's other non-Medicare insured lines of business generally have medical loss ratios of 85–90 percent, with administrative expenses running 8–12 percent of revenue and retained earning of 1–4 percent of revenue.

Question: What is your enrollment weighted average bid in your Private Fee-For-Service product as a percent of FFS? Please provide the same information for your other MA products as well.

Answer: Based on June 2007 enrollment, BCBSM's weighted average bid for 2007 is 105 percent of estimated FFS costs with 2.7 percent accounting for retained earning and 2.3 percent accounting for BCBSM's incremental administrative costs over FFS administration and medical education costs. The weighted average CMS payment to BCBSM (including the rebate payments for 75 percent of the difference between the bid and the benchmark) is 113 percent with the 8 percent difference (113 percent versus 105 percent) going toward supplemental benefits and lower cost sharing provisions for beneficiaries.

These amounts are similar for BCBSM's HMO subsidiary MA plan.

Question: The care coordination program in Private Fee-For-Service is voluntary. What percentage of your Private Fee-For-Service enrollees voluntarily sign up for your care coordination program?

Answer: BCBSM offers two care coordination programs for its MA individual members. Its disease management program, administered through Health Dialog, provides members with access to personal health coaches who supply members with up-to-date, evidence-based health information that focuses on transferring skills and teaching members how to make better health care decisions. All MA Private Fee-For-Service individual enrollees qualify for disease management services and are considered enrolled in the program unless they "opt out". To date, almost 52,000 members, or over 99.75 percent of BCBSM MA individual enrollees participate in the disease management program. Additionally, over 3,000 individual and group members meet Medication Therapy Management eligibility criteria.

BCBSM's other care coordination program—case management and complex care management—is provided through CareGuide. The case and complex care management program provides a full range of health care management services for members, including comprehensive medical and psychosocial care management services for the highest-risk, medically complex members.

Approximately 1,500 members, or 2.8 percent of BCBSM's total MA individual membership, are enrolled in the CareGuide program.

Question from Mr. Doggett to Ms. Block

Question: Please provide us with specific documentation of the process by which CMS identified and acted to curb marketing abuses. Include the number of complaints, all corrective action plans against specific plans and a full detail of other intermediate sanctions levied against plans for marketing abuses. Also provide any interagency memos or reports detailing the extent of abusive marketing practices and possible solutions to the problem.

Answer: (1) Complaints. Data derived from the CMS complaints tracking module (CTM) representing the period January 1, 2006 through May 21, 2007 are summarized below.

MA Marketing Complaints Logged in CTM

2006	2007 (thru 5/21)	Grand Total
94	69	163

Recognizing that these numbers might only be capturing complaints where the caller specifically said the word "marketing," CMS also conducted a focused analysis in April 2007 of the CTM data that involved a word search for "agent" or "broker" in the complaint description. The results of that analysis showed that for the period December 2006 through April 2007, there were approximately 2700 (2679) agent/broker complaints across all CTM categories. Typically the agent/broker complaints had been categorized in the CTM as "enrollment / disenrollment" complaints, rather than in the marketing category.

(2) *Corrective action plans (CAPs).* This information may be sensitive and confidential so we are unable to provide it for the record. The information will be delivered to Committee staff under separate cover. In addition, CMS intends to make summary information on open CAPs publicly available through the CMS website later this year.

(3) *Intermediate sanctions.* CMS imposed 69 sanctions on MA plans in 2006 and 2007 (plus 7 voluntary Private Fee-For-Service marketing suspensions occurring subsequent to this hearing). Of the 69 sanctions imposed, 66 were civil monetary penalties issued in 2007 for delayed Annual Notice of Change (ANOC) deliveries, totaling $308,150. The other three sanctions did not relate to marketing.

(4) *Memos or Reports.* This information may be sensitive and confidential so we are unable to provide it for the record. The information will be delivered to Committee staff under separate cover.

Question from Mr. Becerra to Ms. Block

Question: Please provide for the Committee the pre-enrollment and sales presentation disclaimer language that according to your testimony will be required on all materials so that beneficiaries understand provider access rules in Private Fee-For-Service.

Answer: The language is copied in italics below.

A MA Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital must agree to accept the plan's terms and conditions prior to providing healthcare services to you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may not provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at: [insert link to Private Fee-For-Service terms and conditions].

This language is also required in sales presentations in public venues and private meetings with beneficiaries. Any statement indicating that enrollees may see any provider must also include, the phrase ". . . *who agrees to accept our terms and conditions of payment.*" CMS approval of this language prior to use is not required. Plans should begin using the disclaimer language immediately in sales presentations and as soon as possible in printed materials.

Questions from Mr. Pomeroy to Ms. Block

Question: How many FTEs has CMS added to review all the new Private Fee-For-Service plans to ensure that the cost sharing in these plans is not discriminatory? How many FTEs were added at CMS regional offices to review advertising and other marketing materials of Private Fee-For-Service plans?

Answer: The rapid growth in Private Fee-For-Service plans is not something that was anticipated, which would have been required in order add FTEs for this specific purpose. CMS resources across-the-board are at times stretched very thin, and there certainly is no exception in the MA context. The Agency's ordinary approach for responding to increases in workload is to draw upon existing resources in our central and regional offices to ensure adequate workforce to handle the workload. Staff routinely works overtime and FTEs can be temporarily detailed from other Agency components and provided training to augment existing capabilities. Based on information available, we cannot state that new FTEs were added to the CMS workforce specifically for the purpose of Private Fee-For-Service plan reviews. Plan oversight

is and will continue to be a very high priority at CMS, however, as detailed in previous testimony before this Committee and others.

Question: What type of oversight/audits is CMS conducting to ensure that providers are receiving prompt and adequate payment from Private Fee-For-Service plans?

Answer: CMS audits Private Fee-For-Service organizations as part of its routine program oversight activity. One aspect of the Agency's Private Fee-For-Service audit activity is testing to determine whether Private Fee-For-Service organizations appropriately process claims and make payments to providers and suppliers that are not less than the rates that apply under original Medicare. It is important to note, however, that it is very challenging to replicate with 100% accuracy Medicare fee-for-service payments given the regional variations that in part comprise Medicare fee-for-service payment policy. CMS is committed to improving its oversight of this aspect of the Private Fee-For-Service program. In the meantime, CMS responds quickly to resolve all complaints or concerns regarding provider payment.

[Submissions for the Record follow:]

Statement of American Medical Association

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding Medicare Advantage (MA) Private Fee-For-Service (PFFS) plans. We commend Chairman Stark and Members of the Subcommittee for your leadership in recognizing the need to examine the impact of the PFFS plans on Medicare patients and the long-term financial viability of the Medicare program. While the MA program offered great promise when first introduced, it is in need of some serious surgery. The precursor to MA, Medicare+Choice (M+C), was created to deliver Medicare benefits at lower cost than the regular Medicare fee-for-service program. As Congress has modified the MA option over time, other goals have gained added emphasis, including improving care coordination, increasing beneficiary choices, and, particularly with respect to PFFS plans, expanding access to health plan options for rural communities. The MA program, and especially PFFS plans, have fallen short of these goals in significant, and in some cases, alarming ways.

The AMA supports providing patients with options so that they are able to select the health insurance plan that is tailored to meet their specific needs. The MA option was originally conceived as a strategy to promote efficiency through private competition as well as a vehicle to increase diverse plan offerings that would dovetail with the varied needs of beneficiaries. The AMA has been and continues to be a strong proponent of greater competition in the Medicare program to help strengthen patient choice and the program's long-term financial sustainability. However, rather than competition, the subsidies paid to MA plans tip the balance in favor of the private plans. The average reimbursement to MA plans—112 percent of regular Medicare expenditures—has created significant market distortions and undermined competition. This distortion is magnified by the payments to the PFFS plans, which average 119 percent of Medicare FFS expenditures. PFFS plans are tilting the playing field even further off course than the rest of the MA program. Testimony presented to this Subcommittee by the Congressional Budget Office (CBO) has made it clear that PFFS plans are a significant contributor to its projections of more rapid growth in Medicare spending per beneficiary, just as the baby-boom generation begins to reach the age of Medicare eligibility. The CBO estimated that 21 percent of MA spending goes to private plans that receive between 120 percent and more than 150 percent of regular Medicare rates. The large disparity in payment between PFFS plans and regular Medicare is a particularly troubling development because it is difficult to detect any meaningful benefits either to patients or to rural communities that is derived from these enormous government subsidies. In fact, there is mounting evidence that PFFS plans are luring their enrollees with false promises, skimping on benefits and reimbursement rates, and using their government subsidies primarily to increase profits for their shareholders.

There are real tradeoffs involved in the public policy choices that Congress currently faces. An average 12 percent add-on payment is being provided to plans in which only 19 percent of Medicare beneficiaries are enrolled, while the physicians who care for all Medicare beneficiaries face a 10 percent cut next year. All seniors, not just those in MA plans, are paying $2.00 a month in higher premiums to help fund a subsidy for highly profitable managed care companies. With the PFFS plans, which are the fastest growing component of MA receiving a 19 percent average subsidy, CBO and the Medicare Actuary have noted that Medicare cost growth, which was already a cause of major concern, is now projected to rise even more rapidly.

The AMA joins other health care stakeholders, including the AARP and the Medicare Rights Center, as staunch supporters of financial neutrality between the regular Medicare program and the MA program. As a related corollary the AMA is committed to the goal articulated by the Medicare Payment Advisory Commission (MedPAC) of "having Medicare payments cover the costs that efficient providers incur in furnishing care to beneficiaries, while ensuring that providers are paid fairly and beneficiaries have access to the care they need." The AMA concurs with MedPAC that "the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses."

AMA Surveyed Physicians and Patients Report Problems with PFFS Plans

With payments that average 119 percent of regular Medicare, patients in PFFS plans should be able to obtain coverage that is superior to regular Medicare. In addition, the law requires PFFS plans to pay physicians at least as much as the regular Medicare physician payment rates. Sadly, the results of a recent AMA survey of physicians indicates that patients and their physicians are being shortchanged by these plans. In brief, physicians and their patients have experienced significant obstacles and challenges to receiving health care and/or receiving payment for the health care services that are paid by regular Medicare. The widespread reports about problems faced by physicians and patients have been corroborated by the 2,156 physicians who responded to the AMA survey concerning their experience with MA plans and the PFFS plans in particular. The results illuminate serious and ongoing problems with PFFS plans that are neither isolated nor limited, but are faced by a significant number of physicians and their patients.

Nearly half of the physicians who had patients in PFFS responded that the payment that they received from the PFFS plan was *below* the regular Medicare rate. Equally troubling, 45 percent reported that they have experienced denial of services that are typically covered in the regular Medicare program. Contrary to the widely reported claim that MA plans provide more benefits to patients, physicians are telling us that patients in MA PFFS plans may be getting even fewer benefits than they receive in regular Medicare.

The AMA survey results also lend credence to the reports from beneficiary advocates that marketing by PFFS plan representatives is often misleading and confusing to beneficiaries. An overwhelming number of physicians—eight out of ten—who treated PFFS plan patients stated that their patients have difficulty understanding how the plan works. Providing patients with choices is important, but patients must be provided the tools to make informed choices. PFFS plans have failed in their obligation to provide patients basic information in an accessible and comprehensible fashion. This failure has real consequences for seniors who may have their health care services interrupted or incur significant unanticipated costs when they are least able to afford it.

Good information about PFFS plans is also inaccessible to physicians, so it is no surprise that patients have had difficulty finding physicians who will accept these plans, despite the promises made by sales representatives that patients would be able to go to any doctor. In the AMA survey, over half of the physicians treating PFFS patients stated that they did not have access to or knowledge of the PFFS plans' Terms and Conditions. This alone is cause for a serious examination of PFFS plans, as ready access to Terms and Conditions of payment and coverage is a cornerstone of the PFFS plan concept. If physicians—who are more likely than their patients to have access to resources to secure such information—are experiencing significant difficulty in obtaining this basic information, the hurdles faced by patients—the most vulnerable in particular—should be obvious.

Physicians report a number of additional problems with PFFS plans where they must overcome additional financial and administrative burdens when accepting PFFS beneficiaries. Three out of five plans do not reimburse providers in a timely or accurate fashion. An important underpinning of robust competition is that it should promote streamlining of the administrative process, remove bureaucratic red tape, and enhance the efficient operation of health care delivery. Here again, the responses of the AMA surveyed physicians highlight that PFFS plans are not delivering. Nearly six out of ten physicians indicated that they had experienced excessive hold times when attempting to contact the PFFS plans. Over half stated that PFFS plans have requested excessive or additional documentation for payment of claims. Finally, 30 percent report that PFFS plans use proprietary claims editing software to down code or bundle claims—administrative billing practices that Medicare has not approved for use in regular Medicare. In addition, four out of ten surveyed physicians report they experienced inappropriate payment of claims by PFFS plans. These responses demonstrate that PFFS plans have not enhanced, but instead ham-

pered operational efficiency on the front lines of health care delivery—physician offices—to the detriment of physicians and their patients.

Given physicians' experiences with PFFS plans, it is not surprising that only 52 percent of physicians who have treated patients covered by PFFS plans currently accept all Medicare patients covered by these plans. About a third of these physicians still take some PFFS patients, and 12 percent no longer accept any Medicare patients covered by PFFS plans.

Minority and Rural Patients

Although the insurance industry has issued reports touting the benefits of the MA program to minority and rural beneficiaries, an-even handed look at the data and related analysis paints a different picture. The Center for Budget and Policy Priorities (CBPP) pointed out that Medicaid, not MA, is the main form of supplemental coverage for low-income and minority Medicare beneficiaries. It noted that 58 percent of Asian Americans, 30 percent of African Americans, and 34 percent of Hispanics receive supplemental coverage through Medicaid. In addition, the CBPP analyzed the data offered by America's Health Insurance Plans (AHIP) in a report outlining the benefits of MA. The CBPP concluded based on the AHIP data that low-income and minority beneficiaries participate in MA plans *less* than other Medicare beneficiaries.

In another AHIP report issued on the same day as the one concerning the MA program, but with far less fanfare, AHIP concluded that the supplemental coverage offered by Medigap plans is "particularly important to low- and moderate-income beneficiaries, especially those living in rural areas." As PFFS plans are the most common MA plan for patients in rural areas—the patients that AHIP reports are most reliant on Medigap for their supplemental coverage—it is important to note that Medigap plans do not provide any coverage for MA services. In some cases, therefore, MA plans may actually put patients at higher risk for out-of-pocket costs than they would face if they had remained in the regular Medicare program and kept their Medigap policy. For example, PFFS patients who develop cancer could find the 20 percent cost-sharing for their chemotherapy drugs to be a significant financial burden, whereas the supplemental coverage that even AHIP says is most common among low- and moderate-income rural patients would have covered the cost-sharing for chemotherapy drugs.

MA Plans Have Increased Costs to All Beneficiaries

MA has resulted in higher premiums across the board for all beneficiaries. MedPAC has estimated that on average *every* Medicare beneficiary pays approximately $2.00 per month extra to finance the higher MA payments that only benefit 19 percent of beneficiaries. Equally troubling, PFFS patients who experience a significant health event are subjected to a heightened risk that they will incur higher, unexpected, out-of-pocket costs if they are hospitalized or placed into a nursing home. It has been reported that a number of PFFS plans offer low premiums to attract beneficiaries, but require substantial co-payments. A beneficiary who is hospitalized for a week would be liable for thousands of dollars in out-of-pocket costs. Where patients have regular Medicare and a supplemental Medigap plan, their out-of-pocket expenses would be substantially less in many cases, yet PFFS plans are aggressively marketed and agents receive large commissions in contrast to Medigap. MedPAC and the Medicare Rights Center have reported that MA plans have higher cost-sharing for "nondiscretionary" services such as chemotherapy. This is yet another indicator of the deceptive marketing, financial risks, and consequences patients face, often when they least able to manage the financial burden and interruptions to care.

PFFS Marketing Abuses

There have been rampant PFFS plan marketing abuses reported by physicians and other health care stake holders. Testimony to the Senate's Special Committee on Aging by state insurance commission representatives concerning widespread MA marketing abuses corroborate reports that the AMA has received from physicians. Some of the accounts include a common practice among PFFS plans of signing up patients for plans that end up costing the beneficiary more in out-of-pocket expenses and misleading patients regarding which physicians accept the PFFS plans. Reportedly, many PFFS plans market themselves as providing patients the freedom" to choose any provider that accepts Medicare. As a result, regular Medicare patients sign-up for PFFS with the expectation that they will be able to continue receiving their health care from the same physician they have always had. Although CMS allows patients who have been misled to drop the PFFS plan and re-enroll in regular Medicare and supplemental Medigap plan, this is a difficult, time-consuming process and can impact the delivery of health care services. In addition, once patients will-

ingly drop supplemental Medigap, they are not able to obtain that supplemental coverage if they elect to re-enroll in regular Medicare until and unless they demonstrate that they meet a host of criteria. Even after meeting these requirements the Medigap plan may have less favorable terms. Neither Congress nor CMS have addressed the patient burdens in the past. These abuses have gone uncurbed and have both short-term and long-term consequences to patients.

Government Oversight of PFFS Plans

The AMA first expressed concern to CMS officials about MA PFFS plans in the Fall of 2005, when only an extremely small proportion of seniors had enrolled in these types of plans. A number of state medical societies and individual physicians had already raised questions and concerns about PFFS plans, and the AMA met with CMS officials to discuss them. These officials stated that the most important factor in whether or not a PFFS plan would be successful is physician education.

Many of the early concerns raised by the physician community focused on whether health plans that had employed onerous practices in their private lines of business (such as deeply discounted payment rates, use of claims editing software to bundle or down-code claims, coverage denials, and misleading marketing materials) would be permitted to employ these practices in their PFFS plans. CMS officials made it clear that PFFS plans were expected to ensure that physicians had access to plan Terms and Conditions and that payment rates and coverage were required to mirror that of the regular Medicare program, not the plans' private lines of business. The plans have not met these standards, as evidenced by the AMA survey, and it is clear that the marketing practices of these plans have continued to mislead patients. Further, it does not appear that CMS has increased its scrutiny of these plans or its enforcement.

In its 2004 comment letter on the proposed regulations for MA plans, the AMA urged CMS to actively monitor the MA plans to ensure that laws and regulatory standards that protect patients and physicians in the traditional Medicare program were applied to MA plans. The AMA also expressed a concern, which is now clear was well-founded, that patients might not understand that they had switched from regular Medicare to a MA plan nor be aware that their benefits had changed. At the time AMA provided a number of recommendations—none of which have been implemented—to ensure that beneficiaries had the necessary information to make informed choices about the plan that best suited their needs. Yet, physicians continue to report problems obtaining information concerning their patients' plans, and this is likely one of the reasons that patients have found that their physicians are unwilling to accept the plans. Although CMS officials told the AMA that plans were being encouraged to engage in outreach to physicians in their market areas before marketing of the plans began, there is no evidence that this occurred. In fact, the CMS Call Letter to Medicare Advantage Plans for 2008 bids specifically cited problems with PFFS plans' physician relations. Problems due to lack of outreach are compounded by problems physicians may experience when attempting to navigate PFFS plans' Web sites to locate their Terms and Conditions. As noted in the survey results, the Terms and Conditions can be difficult to find. In addition, certain key information, such as patient cost-sharing amounts, is often not included in the Terms and Conditions. At the AMA's request, CMS has recently been working to rectify these problems and make all PFFS plan Terms and Conditions available in one place.

Information we have received from specific physician practices confirms the findings from our survey that the government is simply not holding PFFS plans to the same standards as regular Medicare. For example, one physician practice wrote to the AMA indicating that a particular PFFS plan was requesting that every laboratory test be submitted as if it were a waived test. They shared further that their radiology procedures were not paid by the MA plan after an extended period of time. When the practice called the private insurance plan customer relations office (based overseas), they were asked by the plan representative whether regular Medicare normally pays for the items in question. In addition, the practice reported that the plan's claims department had no telephone. According to the physician practice, instead of the situation improving over time, the confusion has increased as additional PFFS plans have entered the market.

A Texas nurse wrote to the AMA about her experience as the practice manager of a rural health clinic (RHC). She shared that the RHC received a per visit rate from regular Medicare of $68.13—this amount covers everything provided by the RHC and all codes. However, an administrative and financial nightmare has ensued because while MA plans have informed patients that they can see any physician in the clinic, some of the plans have been unwilling to pay the RHC at the higher rates that it is entitled to receive because it serves a rural community. In fact, the nurse

manager wrote that one MA is paying a rate that is less than half the clinic's RHC rate. Far from increasing access to rural beneficiaries, MA plans could well result in fewer rural physicians being able to accept Medicare patients.

Likewise, a physician from Georgia complained about a plan representative going door-to-door signing up beneficiaries for their PFFS plan. She said seniors then arrive for treatment and have no idea that they signed up for PFFS. The beneficiary will still present their old regular Medicare card. When the physician receives coverage denials, she phones the plan's customer service center, which is based in another country. She has concerns that she must provide patient Social Security Numbers and other personally identifiable information to an entity based in a foreign country. She is wondering what CMS plans to do about these issues.

These examples underscore that the failure of the government to provide oversight results in serious and real consequences for physicians and patients alike. PFFS have established time consuming, confusing, and burdensome procedures and processes that create inefficiencies and detract from the provision of health care.

PFFS Plans Have Generated Large Profits for Private Insurance Companies

When Congress set up the payment system for MA plans, it may have intended for the extra payments to support health care services. In the AMA physician survey and reports by patient advocates, the PFFS plans are not delivering on this promise. The subsidies to PFFS plans are substantial, create market distortions, and are inefficient. Who then benefits from the subsidies? As of November 2006 the MA market was dominated by four firms that accounted for 58 percent of all MA enrollment. There have been reports that private insurance companies have reaped substantial profits from the Medicare program. For example, in February 2007 the Associated Press reported that one of the companies "fourth-quarter profit more than doubled on the strength of its burgeoning Medicare business" and the company had "a record year in revenue and profit." Recently, Goldman Sachs reported that the same company "will earn 66 percent of its net income from Medicare Advantage this year . . . which comes to between $670 million and $705 million."

Medicare FFS Remains the Primary Medicare Option and It Must be Preserved

Physicians were there before the M+C and MA programs were created, they continued providing care to patients when many private health plans did not participate because M+C was not profitable enough, and physicians will be there should the health plans find a better business opportunity. Although many physicians provide health care to MA patients, they have many more patients who are in regular Medicare—81 percent. Huge subsidies are going to MA plans that serve 19 percent of Medicare beneficiaries, while physicians who take care of the rest of the population face cuts of 10 percent in 2008 and about 40 percent over the next decade. If Congress does not take action to provide Medicare physician payment updates that keep up with cost increases, the physicians will not be able to sustain their practices, resulting in significant access problems for all patients, not just those in regular Medicare or even just those in Medicare. There is a tradeoff between adequate payment updates for physicians and subsidies for private health insurance plans such as PFFS. Congress must now decide whether adequate payment updates for regular Medicare physician services are provided or whether MA plans should continue to receive these substantial subsidies. Until MA plans are placed on equal footing with regular Medicare, the market distortions will continue to encourage inefficient behavior by MA plans, patients and physicians will face added financial risks, delivery of health care will be compromised, and taxpayers will pay more (seemingly for less).

The AMA appreciates the opportunity to provide our views to the Health Subcommittee concerning PFFS plans. We look forward to working with the Subcommittee and Congress to preserve patient access to high quality, cost-effective health care and to find solutions to address the long-term financial sustainability of the Medicare program.

Statement of Janet Stokes Trautwein, National Association of Health Underwriters, Arlington, Virginia

The National Association of Health Underwriters (NAHU) is the leading professional trade association for health insurance agents and brokers ("producers"), representing more than 20,000 health insurance producers nationally. Our members service the health insurance policies of millions of Americans and work on a daily basis to help individuals and employers purchase health insurance coverage. We

have thousands of members across the country who specialize in the sale of "senior products," including all Medicare-related insurance products such as Medigap and all of the options under Medicare Advantage.

While NAHU commends the Subcommittee for taking up this important issue, we hope that in the course of its work the Subcommittee does not undertake any actions that would limit the ability of seniors to access either Medicare Advantage plans or the services of licensed professional health insurance producers. Medicare Advantage may not be the right choice for every senior, but there are many Medicare beneficiaries who are very happily insured under these plans. NAHU feels it is very important that all Americans, including Medicare beneficiaries, have a wide range of health plan choices available to them and are able to pick the policy that best suits their individual needs.

Medicare Advantage private fee-for-service plans can provide enrollees with the flexibility to choose their own provider while offering them a number of benefits that traditional Medicare does not cover. Medicare Advantage fee-for-service policies offered by many carriers often include coverage of prescription drugs as well as other benefits, such as world travel coverage, full coverage of preventive care, vision benefits, chiropractic coverage and more. These plans also offer seniors fixed co-payment and coinsurance amounts for services, rather than the uncertainty of what their 20 percent responsibility would be under traditional Medicare. It is not surprising that many seniors who have not been able to afford supplemental coverage due to their limited incomes find these plans particularly attractive and sales have increased over the past year.

Another population that Medicare Advantage private fee-for-service plans ably serves are Medicare beneficiaries who are under the age of 65, such as certain disabled individuals and those with end-stage renal disease. There is no federal requirement for health insurance carriers that sell Medicare supplemental policies, which are also known as Medigap plans, to this population, as these polices are designed for the traditional senior Medicare beneficiary. So in most states, these individuals are unable to purchase Medicare supplemental coverage. In the few states where they can purchase Medigap policies, beneficiaries under the age of 65 are faced with state-mandated limited-enrollment windows, limited product availability and costs that are frequently very high.

On the other hand, Medicare disabled beneficiaries are able to purchase Medicare Advantage plans in every state. The availability of these plans has helped thousands of beneficiaries who otherwise would be completely exposed to the out-of-pocket costs that regular Medicare doesn't cover. These individuals are of all ages and, in many cases, they are very ill and appreciate the flexibility of provider choice offered under the Medicare Advantage private-fee-for-service plans. Medicare Advantage fee-for-service plans regularly help them financially and with quality-of-life issues by providing them with affordable access to benefits not covered under Medicare Parts A and B.

NAHU also thinks it is crucial that all Americans have the ability to use licensed health insurance professionals to help them choose the health plan products that best meet their specific needs. The vast majority of licensed producers who sell Medicare Advantage plans to seniors specialize in this unique market. These professionals spend countless hours advising their clients, answering questions and helping to select the best possible plan options based on their clients' budgets and personal preferences.

NAHU is well aware of some recent publicity depicting a few "bad apples" in our industry who have been behaving in what appears to be an unethical manner concerning Medicare Advantage private fee-for-service product sales. However, it is important to note the vast majority of health insurance producers work very hard every day to find quality and appropriate health coverage at the best possible price for millions of employers, individuals and families. It would be a disservice to the thousands of high-caliber health insurance producers out there, and their millions of happily insured senior clients, if access to licensed health insurance producers was in any way limited. The actions of a dishonest few should not be interpreted as representative of our entire industry.

NAHU members are committed to education. As a result, our association has spent considerable time, effort and resources educating our members about the rules concerning Medicare-related product sales, and we will continue to do so. To ensure that NAHU members are equipped with the most up-to-date and accurate information on marketing Medicare plans, during the past year NAHU, along with America's Health Insurance Plans (AHIP), established a four-part education program on Medicare, Medicare Part D and Medicare Advantage. The NAHU/AHIP course teaches the marketing rules and responsibilities of each program and, like all of NAHU's many education programs, it covers and encourages ethical professionalism.

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This class has been approved for continuing-education credit in more than forty states, and we are actively promoting the course to NAHU members and non-members alike.

NAHU is also committed to working with the Centers for Medicare and Medicaid Services (CMS) and individual states on producer education, as we feel that there are many producers out there who may not specialize in Medicare or senior products and who are not NAHU members. To try to reach these producers, NAHU has published a vast amount of Medicare-related product sales information on our website, which is open to the public. We would also be happy to post any additional information on our site that CMS or state departments of insurance develop, as well as link to other sites or reach out to non-member producers for education purposes in collaboration with CMS and state departments of insurance. We would also be happy to help spread the word to seniors, to make sure they know the warning signs of an unethical agent and what to expect from a responsible health insurance producer.

NAHU wants to be as helpful as possible to policymakers as they consider ways to sustain and enhance the integrity of the Medicare Advantage program and, in the process, protect beneficiaries from unscrupulous producers. Two initiatives in particular that would help to improve the regulation of Medicare Advantage plans and communication processes about these plans are the appointment of health insurance producers and the expansion of the Medicare Advantage/Part D open-enrollment window. In the vast majority of states, health insurance producers not only have to be licensed, but they also must be appointed with the carriers for which they sell products. This appointment information is made available to the state departments of insurance so that the state knows which producers are approved to sell which products offered by particular companies operating within its borders. While producers selling Medicare Advantage policies are required to be licensed, under current law they do not have to be appointed. Some carriers have voluntarily completed the appointment process with their producers and provided this information to the states. NAHU feels that mandatory appointments for Medicare Advantage plans would help the state departments of insurance, and help to weed out the number of unethical producers preying on this market.

NAHU would also like to see the annual open-enrollment period for beneficiaries lengthened, perhaps from October 1st through December 31st of each year. Millions of Medicare beneficiaries are asked to review their benefits and possibly change plans each year. Many of these beneficiaries need assistance with the open-enrollment process and are afraid of making a bad decision. Ethical producers need more time to personally counsel each client, but the limited open-enrollment time period makes it very difficult. Compounding the problem is that the Medicare open enrollment coincides with the holiday season, with Thanksgiving, Hanukkah and Christmas to work around. Also, many Medicare beneficiaries (so-called "snowbirds") maintain second residences and spend the colder months of November and December in warmer climates, making them less able to see a plan representative or agent at this time of year.

CMS actively encourages Medicare beneficiaries and their insurance producers to complete the open-enrollment process as early as possible, as those who sign up late in the month of December are not able to be fully processed and have ID cards sent to them until well after their plan's January 1st effective date. Making the open-enrollment period a little longer and a little earlier in the year would make the process much easier on beneficiaries and those providing enrollment support. It also would enable more seniors to seek counsel from a high-quality insurance producer and not feel as susceptible to pressure and the aggressive sales tactics should they encounter a "bad apple."

NAHU sincerely appreciates the opportunity to provide comment on Medicare Advantage plans to the Subcommittee. If you have any questions, or if NAHU can be of further assistance, please do not hesitate to contact me or our vice president of congressional affairs, Peter Stein.

Respectfully submitted,

Janet Trautwein
Executive Vice President and CEO

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